

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04341

Reg. Dist. No.

242

4390

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kentland			c. LENGTH OF STAY IN lb 9 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kentland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7628 Hawthorne Street				d. STREET ADDRESS 7628 Hawthorne Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Leonard Last Alvey				4. DATE OF DEATH Month April Day 16 Year 19 57			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-21-20	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer and sider	
10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward T. Alvey	
14. MOTHER'S MAIDEN NAME Rose E Hancock		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Charles E. Alvey; Columbia Park-Landover, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation DUE TO (b) Hanging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging by the neck			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 4-16- 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) kentland-- Prince Georges, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED April 16, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gasch's Sons Hyattsville, Maryland.							
24a. REC'D BY REGISTRAR DATE 22 1957				24b. REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation or removal.

RECEIVED

APR 22 1957

BUREAU V. 3

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John F. Edwards, M.D.	
Sex		Male	
Age		37	
Date of Death		April 19, 1957	
Place of Death		Hospice, Charleston, West Virginia	
Cause of Death		Hypertension, congestive heart failure, coronary artery disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	

CERTIFICATE OF DEATH

Reg. Dist. No.

4391

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. Carolina</u> b. COUNTY <u>Cumberland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edmonston</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>4902-52nd pl</u>		e. STREET ADDRESS <u>433-Duck St</u>	
3. NAME OF DECEASED (Type or print) <u>Blanche Hedley</u> First <u>Batton</u> Middle <u>Batton</u> Last		4. DATE OF DEATH Month <u>apr</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1892</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>N Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Hubbard</u>		14. MOTHER'S MAIDEN NAME <u>not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Vernon Batton</u>		Address <u>Edmonston Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO (c) <u>5 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>apr 14</u> , 19 <u>57</u> , to <u>apr 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>apr 14</u> , 19 <u>57</u> , and that death occurred at <u>445</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>4-16-57</u>	
PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>		<u>Riverdale, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/19/57</u>	<u>Cumberland</u>	<u>Cumberland Co. North Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Buschman Fayetteville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 18 1957</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>H. H. Kennedy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

APR 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04343

4392

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2223-Jameson Street		d. STREET ADDRESS 12223 Jameson Street	
3. NAME OF DECEASED (Type or print) Carl Bauman		4. DATE OF DEATH April 10 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1911
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Food	
11. BIRTHPLACE (State or foreign country) Paris, France		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Karl Bauman		14. MOTHER'S MAIDEN NAME Jeanne E. Gogert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-46-8433	
17. INFORMANT Mrs Lena Bauman		Address Ames #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 13-57	
22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Annand Bros		ADDRESS 1661 Good Hope Rd	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
(MEDICAL EXAMINER'S CERTIFICATE OF DEATH)

BUREAU V. 5

APR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04344

4338

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville			c. LENGTH OF STAY IN 1b 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 West Hyattsville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3407 Nicholson Street				d. STREET ADDRESS 3407 Nicholson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francis Middle I Last Beach				4. DATE OF DEATH Month April 20, Day Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/6/1876	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pressman, U.S. Govt Printing Office		10b. KIND OF BUSINESS OR INDUSTRY D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Daniel W. Beach				14. MOTHER'S MAIDEN NAME Sarah Belton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 579-14-5678-A		17. INFORMANT Elizabeth H. Beach,		Address wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility (c) Generalized arteriosclerosis with Hemiplegia & Aphasia						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 19, 1956, to April 20, 1957, that I last saw the deceased alive on April 18, 1957, and that death occurred at 9:00 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE R. S. Fleischer				ADDRESS (Street, city or town, state) 5432 Queens Chapel Rd			
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER				DATE SIGNED 4/20/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/24/57		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				ADDRESS Wash, D.C.		24a. REC'D BY REGISTRAR DATE April 23 1957	
24b. REGISTRAR'S SIGNATURE Mrs. Jas. Sorensen				24c. REGISTRAR'S SIGNATURE Refuses			

CERTIFICATE OF DEATH

1957

Name of Deceased W. H. HARRIS		Sex Male		Age 3 yrs		Race White	
Date of Birth April 10, 1954		Date of Death April 10, 1957		Place of Birth Baltimore, Md.		Place of Death Baltimore, Md.	
Residence 3007 Highland Street		Occupation None		Cause of Death Sudden Infant Death Syndrome		Manner of Death Natural	
Signature of Physician [Signature]		Signature of Coroner [Signature]		Signature of Registrar [Signature]		Signature of Witness [Signature]	
Name of Physician Daniel W. French		Name of Coroner Elizabeth H. French		Name of Registrar [Name]		Name of Witness [Name]	
Address of Physician [Address]		Address of Coroner [Address]		Address of Registrar [Address]		Address of Witness [Address]	
City of Physician Baltimore		City of Coroner Baltimore		City of Registrar Baltimore		City of Witness Baltimore	
State of Physician Md.		State of Coroner Md.		State of Registrar Md.		State of Witness Md.	
County of Physician Baltimore		County of Coroner Baltimore		County of Registrar Baltimore		County of Witness Baltimore	
Zip of Physician 21201		Zip of Coroner 21201		Zip of Registrar 21201		Zip of Witness 21201	
Date of Report April 10, 1957		Date of Death April 10, 1957		Date of Burial April 10, 1957		Date of Cremation None	
Name of Burial Place [Name]		Name of Crematorium None		Name of Funeral Home [Name]		Name of Undertaker [Name]	
Address of Burial Place [Address]		Address of Crematorium None		Address of Funeral Home [Address]		Address of Undertaker [Address]	
City of Burial Place Baltimore		City of Crematorium None		City of Funeral Home Baltimore		City of Undertaker Baltimore	
State of Burial Place Md.		State of Crematorium None		State of Funeral Home Md.		State of Undertaker Md.	
County of Burial Place Baltimore		County of Crematorium None		County of Funeral Home Baltimore		County of Undertaker Baltimore	
Zip of Burial Place 21201		Zip of Crematorium None		Zip of Funeral Home 21201		Zip of Undertaker 21201	

BUREAU V. 3

APR 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04345

4350

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bowie, MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Bell</u> Last <u>Bell</u>		4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Taylor Gardner</u>		14. MOTHER'S MAIDEN NAME <u>Minerva Disney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1943</u> , 19 <u>April 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 5</u> , 19 <u>57</u> , and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John R. Buell</u>		ADDRESS (Street, city or town, state) <u>402 MAIN ST - LAUREL MD</u>	
PHYSICIAN'S NAME (Type) <u>John R. Buell</u>		DATE SIGNED <u>4/6/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/8/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		22d. LOCATION (City, town, or county) <u>Patuxent Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Lewis</u>	

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18 4351 CERTIFICATE OF DEATH

04346

Reg. Dist. No.

745

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 4710 Tecumseh Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATINKA Middle BARBARA Last BEWLEY		4. DATE OF DEATH Month April Day 23 Year 19 57					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH November 18, 1871	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Bonnet				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT S. Marguerite Willingmyre, 1918 Edgewater Pkwy,		Address S.Sp.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Bilateral Secondary Congestion (b) Chr Congestive Heart Failure (c) DUE TO Aortic sclerotic Heart Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-18-57 to 4-23-57, that I last saw the deceased alive on 4-23-57, and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE		W. Etienne, Md.		ADDRESS (Street, city or town, state) College Park, Md.		DATE SIGNED 4/23/57	
PHYSICIAN'S NAME (Type) W. Etienne, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE R. Gasch's Sons Hyattsville, Md.		22d. LOCATION (City, town, or county) Colmar Manor Md.		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE James Leavelle	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White		5. DATE OF BIRTH 12-1-22		6. PLACE OF BIRTH Jackson, Mississippi	
7. DATE OF DEATH 4-4-68		8. TIME OF DEATH 10:00 AM		9. PLACE OF DEATH FBI Office, Memphis, Tennessee		10. CAUSE OF DEATH Suicide		11. MANNER OF DEATH Homicide		12. ICD-9 CODE 276.21	
13. SIGNATURE OF DECEASED (None)		14. SIGNATURE OF NEXT OF KIN None		15. SIGNATURE OF PHYSICIAN None		16. SIGNATURE OF MORTUARY None		17. SIGNATURE OF REGISTRAR None		18. SIGNATURE OF WITNESSES None	
19. NAME OF PHYSICIAN None		20. NAME OF MORTUARY None		21. NAME OF REGISTRAR None		22. NAME OF WITNESSES None		23. NAME OF NEXT OF KIN None		24. NAME OF DECEASED JAMES EARL RAY	
25. NAME OF PHYSICIAN None		26. NAME OF MORTUARY None		27. NAME OF REGISTRAR None		28. NAME OF WITNESSES None		29. NAME OF NEXT OF KIN None		30. NAME OF DECEASED JAMES EARL RAY	

BUREAU V. 3

APR 29 1968

RECEIVED

CERTIFICATE OF DEATH

4339

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOME				d. STREET ADDRESS #3805 12th. St. N. E.			
3. NAME OF DECEASED (Type or print) ROSE L. BISHOP				4. DATE OF DEATH Apr. 19 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-30-71	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME Daniel C. McGivern				14. MOTHER'S MAIDEN NAME Eliza O'Rourke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. no			
17. INFORMANT Mrs. Fred Koerbel				Address Wash. D. C. 5415 Conn. Ave. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 yr 5 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 9 1952 to April 19 1957 , that I last saw the deceased alive on April 18 1957 , and that death occurred at 10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert R. Hotte M.D.				ADDRESS (Street, city or town, state) 1222 Monroe St NE Washington DC			
PHYSICIAN'S NAME (Type) Robert R. Hotte				DATE SIGNED APR 22 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 22/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS Wash. D.C. 3822 14th. N.W.				24a. REC'D BY REGISTRAR APR 22 1957 24b. REGISTRAR'S SIGNATURE James			

CERTIFICATE OF DEATH

DATE OF DEATH 1952		PLACE OF DEATH HOSPITAL	
DECEASED J. C. D.		DECEASED J. C. D.	
DATE OF BIRTH 1912		DATE OF BIRTH 1912	
PLACE OF BIRTH BALTIMORE, MD		PLACE OF BIRTH BALTIMORE, MD	
SEX M		SEX M	
RACE WHITE		RACE WHITE	
EDUCATION HIGH SCHOOL		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		OCCUPATION LABORER	
MARRIAGE MARRIED		MARRIAGE MARRIED	
DATE OF MARRIAGE 1935		DATE OF MARRIAGE 1935	
NAME OF SPOUSE J. C. D.		NAME OF SPOUSE J. C. D.	
NAME OF DECEASED J. C. D.		NAME OF DECEASED J. C. D.	
ADDRESS BALTIMORE, MD		ADDRESS BALTIMORE, MD	
CITY BALTIMORE		CITY BALTIMORE	
STATE MD		STATE MD	
COUNTRY U.S.A.		COUNTRY U.S.A.	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL	
SIGNATURE OF DECEASED J. C. D.		SIGNATURE OF DECEASED J. C. D.	
SIGNATURE OF WITNESS J. C. D.		SIGNATURE OF WITNESS J. C. D.	
SIGNATURE OF PHYSICIAN J. C. D.		SIGNATURE OF PHYSICIAN J. C. D.	
SIGNATURE OF CORONER J. C. D.		SIGNATURE OF CORONER J. C. D.	
SIGNATURE OF JURY J. C. D.		SIGNATURE OF JURY J. C. D.	
SIGNATURE OF JUDGE J. C. D.		SIGNATURE OF JUDGE J. C. D.	
SIGNATURE OF CLERK J. C. D.		SIGNATURE OF CLERK J. C. D.	
SIGNATURE OF DECEASED J. C. D.		SIGNATURE OF DECEASED J. C. D.	
SIGNATURE OF WITNESS J. C. D.		SIGNATURE OF WITNESS J. C. D.	
SIGNATURE OF PHYSICIAN J. C. D.		SIGNATURE OF PHYSICIAN J. C. D.	
SIGNATURE OF CORONER J. C. D.		SIGNATURE OF CORONER J. C. D.	
SIGNATURE OF JURY J. C. D.		SIGNATURE OF JURY J. C. D.	
SIGNATURE OF JUDGE J. C. D.		SIGNATURE OF JUDGE J. C. D.	
SIGNATURE OF CLERK J. C. D.		SIGNATURE OF CLERK J. C. D.	

BUREAU V. S.

APR 22 1957

RECEIVED

4352

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 15 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence				d. STREET ADDRESS 2714 Cheverly Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MAURICE LEROY BITTING				4. DATE OF DEATH Month April Day 8 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1904	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Bitting				14. MOTHER'S MAIDEN NAME Mary Kenapp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-10-7131		17. INFORMANT Mrs. Victoria M. Bitting Address 2714 Cheverly Ave., Cheverly, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 1 hour
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Colmar Manor, Fr. Geo. Co. Md.				20g. (County) (State)			
21. I certify that I attended the deceased from Feb. 2, 1957 to 4/8/57 , that I last saw the deceased alive on 2/26/57 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. E. Musser M.D.				ADDRESS (Street, city or town, state) 2409 VERNUM ST. Landover Hills, Md.			
DATE SIGNED 4/8/57							
PHYSICIAN'S NAME (Type) FREDERICK E. MUSSER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 11/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Fr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Md.				24a. REC'D BY REGISTRAR APR 11 57		24b. REGISTRAR'S SIGNATURE DeF...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4353 Items 8/511-G211, 1-26-57 et
CERTIFICATE OF DEATH

Reg. Dist. No.

04349

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN Ib <u>4 hrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville,</u>		d. STREET ADDRESS <u>500h 37th Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Horan</u> Last <u>Blancke</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/11/ 1917 1877</u>
9. AGE (In years lost birthday) <u>'79</u> yrs.		10. AGE (In years lost birthday) <u>'79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during last year of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Castle Island, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Horan</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Andre J. Blancke</u>		Address <u>3709-Kennedy Pl. West Hyattsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary heart disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-15</u> , 19 <u>57</u> , to <u>4-16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-16</u> , 19 <u>57</u> , and that death occurred at <u>2.30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. W. Chambers</u> M.D.		ADDRESS (Street, city or town, state) <u>1432 QUEENS CHATEL RD</u> DATE SIGNED <u>4/17</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Fleischer</u>		<u>HYATTSVILLE, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-20- '57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>W. Hyatts. P. George Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>5801-Cleveland Ave. RIVERDALE MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 23 '57</u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4349 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1,7 FilmG211 4-22-57 et
CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Pr Geo G</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6823 New Hampshire Avenue</u>		d. STREET ADDRESS <u>16723 N. Hampshire Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>George H.</u> Middle <u>Brun</u> Last <u>Brun</u>		4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-72</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Brun</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Flora Brun</u>		Address <u>6723 N. Ham</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile dementia of Alzheimer</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-6-56</u> , 19 <u>56</u> , to <u>4-7-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-6-57</u> , 19 <u> </u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. Clark</u>		ADDRESS (Street, city or town, state) <u>Hyattsville Md</u>	
PHYSICIAN'S NAME (Type) <u>W. A. Huntewans & Son</u>		DATE SIGNED <u>4-7-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Huntewans & Son</u>		24a. REC'D BY REGISTRAR <u>am</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>		DATE <u>4-15-1957</u>	

RECEIVED

4393

CERTIFICATE OF DEATH

Reg. Dist. No.

04351

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Baden</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home - Brandywine, Md</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES Edward Bryan</u>				4. DATE OF DEATH Month Day Year <u>April 28 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27, 1917</u>	9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Thomas E. Bryan</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Carter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Thomas E. Bryan Baden, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>351X Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Infection & Congenital Defects</u> DUE TO (c) <u>Spontaneous Pulses</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-20</u> , 19 <u>55</u> , to <u>4-28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-25</u> , 19 <u>57</u> , and that death occurred at <u>1:00 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D.				DATE SIGNED <u>Brandywine Md</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>				<u>Brandywine Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>April 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>				24a. REC'D BY REGISTRAR <u>DATE 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

4354

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>J</u> Last <u>Budzko</u>				4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 1, 1899</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>11</u> Hours <u>58</u> Min.	
11. BIRTHPLACE (State or foreign country) <u>Mt. Carmel, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Anthony Budzko</u>				14. MOTHER'S MAIDEN NAME <u>Mary ZUKOWSKI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>"</u>		17. INFORMANT Address <u>KULPMONT PA.</u> <u>Ignatius Nowakowski</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Gastro-Intestinal hemorrhage</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Ruptured Esophageal Varix</u> DUE TO (c) <u>Portal Cirrhosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 9</u> , 19 <u>57</u> , to <u>April 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>57</u> , and that death occurred at <u>10</u> <u>PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leah L. Lintzky</u>				M.D. <u>4403 28th Place Mt Rainier Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Leon R. Lintzky</u>				<u>4403 28th Place Mt Rainier Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home Inc.</u>				ADDRESS <u>Mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 17 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF WITNESS		24. SIGNATURE OF PHYSICIAN		25. SIGNATURE OF REGISTRAR	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF NEXT OF KIN		28. SIGNATURE OF WITNESS		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF REGISTRAR	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF WITNESS		34. SIGNATURE OF PHYSICIAN		35. SIGNATURE OF REGISTRAR	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF NEXT OF KIN		38. SIGNATURE OF WITNESS		39. SIGNATURE OF PHYSICIAN		40. SIGNATURE OF REGISTRAR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF WITNESS		44. SIGNATURE OF PHYSICIAN		45. SIGNATURE OF REGISTRAR	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF NEXT OF KIN		48. SIGNATURE OF WITNESS		49. SIGNATURE OF PHYSICIAN		50. SIGNATURE OF REGISTRAR	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF NEXT OF KIN		53. SIGNATURE OF WITNESS		54. SIGNATURE OF PHYSICIAN		55. SIGNATURE OF REGISTRAR	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF NEXT OF KIN		58. SIGNATURE OF WITNESS		59. SIGNATURE OF PHYSICIAN		60. SIGNATURE OF REGISTRAR	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF WITNESS		64. SIGNATURE OF PHYSICIAN		65. SIGNATURE OF REGISTRAR	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF NEXT OF KIN		68. SIGNATURE OF WITNESS		69. SIGNATURE OF PHYSICIAN		70. SIGNATURE OF REGISTRAR	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN		73. SIGNATURE OF WITNESS		74. SIGNATURE OF PHYSICIAN		75. SIGNATURE OF REGISTRAR	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF WITNESS		79. SIGNATURE OF PHYSICIAN		80. SIGNATURE OF REGISTRAR	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF WITNESS		84. SIGNATURE OF PHYSICIAN		85. SIGNATURE OF REGISTRAR	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF NEXT OF KIN		88. SIGNATURE OF WITNESS		89. SIGNATURE OF PHYSICIAN		90. SIGNATURE OF REGISTRAR	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF WITNESS		94. SIGNATURE OF PHYSICIAN		95. SIGNATURE OF REGISTRAR	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF NEXT OF KIN		98. SIGNATURE OF WITNESS		99. SIGNATURE OF PHYSICIAN		100. SIGNATURE OF REGISTRAR	

BUREAU V. 2

APR 17 1957

RECEIVED

4394

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)				c. LENGTH OF STAY IN 1b 5 yrs, 5 mo's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale, Maryland				d. STREET ADDRESS 140 - 12 th St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fred Middle S. Last Burton				4. DATE OF DEATH Month April Day 5 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/22/92	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & manager				10b. KIND OF BUSINESS OR INDUSTRY lunch room		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Sherman Burton				14. MOTHER'S MAIDEN NAME Laura Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 225-10-2812		17. INFORMANT Decedent Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 002x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary tuberculosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 months 5 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 17, 1952, to April 5, 1957, that I last saw the deceased alive on April 5, 1957, and that death occurred at 7:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Moe Weiss				ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital, Glenn Dale, Md. 4/5/57			
PHYSICIAN'S NAME (Type) Moe Weiss							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/57		22c. NAME OF CEMETERY OR CREMATORY Congressional		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rinaldi Funeral Home Washington				24a. REC'D BY REGISTRAR DATE APR 9 '57		24b. REGISTRAR'S SIGNATURE W. Leach	

RECEIVED

APR 9 1957

BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10	
CERTIFICATE OF DEATH	
NAME OF DECEASED	
DATE OF DEATH	
PLACE OF DEATH	
CAUSE OF DEATH	
MANNER OF DEATH	
AGE	
SEX	
RACE	
BIRTH DATE	
BIRTH PLACE	
EDUCATION	
OCCUPATION	
MARRIAGE	
PREVIOUS ILLNESS	
HISTORY OF DEATH	
SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN	
SIGNATURE OF CORONER	
SIGNATURE OF JUDGE	
SIGNATURE OF CLERK	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please retrace carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 1, 2 Film 0214 4-24-57 et
4395
CERTIFICATE OF DEATH

04354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marlboro				c. LENGTH OF STAY IN 1b since 1924			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marquerite H Chapman				4. DATE OF DEATH April 11 1957			
5. SEX F.		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9.28.97.	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) 202 D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William B. Booker				14. MOTHER'S MAIDEN NAME Nettie Harper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Chapman		Address Spring Dr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma - head of pancreas DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 weeks 5 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1 Dec. 1956 , to 11 Apr. 1957 , that I last saw the deceased alive on 10 Apr. 1957 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro Md DATE SIGNED 11 Apr 57 ACTUAL SIGNATURE R.B. Sasscer M.D. PHYSICIAN'S NAME (Type) R.B. Sasscer Upper Marlboro, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		4.25.57		Mt. Carmal Cemetery		Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Norman M. Miller Washington, D.C.				24a. REC'D BY REGISTRAR DATE APR 15 '57		24b. REGISTRAR'S SIGNATURE W. E. Smith	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RACE		10. RELIGION	
11. DATE OF DEATH		12. TIME OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
21. SIGNATURE OF CLERK		22. SIGNATURE OF CHIEF CLERK		23. SIGNATURE OF ASSISTANT CLERK		24. SIGNATURE OF DEPUTY CLERK		25. SIGNATURE OF CLERK IN CHARGE	

BUREAU V. S.

APR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04355

4396

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Hill</u>			c. LENGTH OF STAY IN 1b <u>Transient</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Hill</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7300 Block Old Fort Road</u>				d. STREET ADDRESS <u>8910 Old Fort Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Desayles</u> Last <u>Chew</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1957</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 5, 1918</u>		
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Chew</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Queen</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Maggie Chew, 8910 Old Fort Road, Chapel Hill, Md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Pulmonary Tuberculosis</u> (c), stating the underlying cause last. </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>James I. Boyd</u>				DATE SIGNED <u>April 26, 1957</u>				
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Berwyn Rd SE N.E.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson & Jenkins 4804 Ga Ave NW</u>				24a. REC'D BY REGISTRAR <u>DATE 7 57</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

BUREAU V. 2

MAY 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4355 Item 9 Film G214 5-1-57 et
CERTIFICATE OF DEATH

Reg. Dist. No. 04356

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheverly</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5711 Euclid ST.</u>				d. STREET ADDRESS <u>15711 Euclid ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>F.</u> Last <u>CHWALEK</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 19, 1893</u>	
9. AGE (In years last birthday) <u>63 1/2</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>15</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>guard</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BANK</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Chwalek</u>				14. MOTHER'S MAIDEN NAME <u>ANTONINA VIETOWSKA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>MRS HELENA CHWALEK</u> Address <u>5711 Euclid St. Cheverly Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO <u>154X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adeno CARCINOMA OF RECTUM</u> DUE TO (c) <u>15 mos.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>15 mos.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>4:30</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>JAN 23, 1956</u> to <u>APRIL 22, 1957</u> , that I last saw the deceased alive on <u>APRIL 22, 1957</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Brown</u> M.D. <u>3503 Perry St. Mt</u>				ADDRESS (Street, city or town, state) <u>4/22/57</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT BROWN</u>				DATE SIGNED <u>4/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville Maryland.</u>				ADDRESS <u>DATE</u>		24a. REC'D BY REGISTRAR <u>APR 24 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Outreach</u>							

RECEIVED

4397

CERTIFICATE OF DEATH

Reg. Dist. No.

243

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie Rural</u>		c. LENGTH OF STAY IN 1b <u>25 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural x2 — Bowie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Glascoe Colen</u>				4. DATE OF DEATH Month Day Year <u>4 - 13 - 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11, 1825</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Colen</u>				14. MOTHER'S MAIDEN NAME <u>Susan Payne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Rebecca F. Colen</u>		Address <u>Bowie, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>591X Congestive Heart Failure</u> DUE TO (b) <u>Nephrosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrene of left foot</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 14, 1957</u> , to <u>April 13, 1957</u> , that I last saw the deceased alive on <u>April 13, 1957</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry G. T. Wise, Jr.</u>				ADDRESS (Street, city or town, state) <u>M.D. 149 9th St Bowie md</u>			
PHYSICIAN'S NAME (Type) <u>Henry A. Wise, Jr.</u>				DATE SIGNED <u>4/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/16/57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Wood Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Magruder</u>				ADDRESS <u>2311 Nichols Ave. S.E.</u>		24a. REC'D BY REGISTRAR <u>APR 18 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Agnes Young</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 18 1957

RECEIVED

4398

CERTIFICATE OF DEATH

Reg. Dist. No.

234

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Pr. Geo's Co. Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X6 Temple Hills Maryland.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home 4450--Whitehall St.				d. STREET ADDRESS 4817-- Leslie Ave., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE LEMUEL COOK				4. DATE OF DEATH Month Day Year April 11th 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 15- 1870	
9. AGE (In years last birthday) yrs. 87		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Truck Farmer		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Thomas Cook Thomas Cook.			
14. MOTHER'S MAIDEN NAME Unknown.				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Charles Ross Cook. 4817- Leslie Ave. S.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, prostate gland</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis - Congestive Heart Failure</u>							INTERVAL BETWEEN ONSET AND DEATH 6 yrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) —				20b. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20c. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20e. (City or town) Suitland, Maryland.				20f. (County) (State)			
21. I certify that I attended the deceased from Nov 21, 1949, to April 11, 1957, that I last saw the deceased alive on April 11, 1957, and that death occurred at 7:35 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo H. Hugmon				ADDRESS (Street, city or town, state) 2711 GAITHER ST. SE			
DATE SIGNED 4/11/57				M.D.			
PHYSICIAN'S NAME (Type) LEO H. HUGMON, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 15-1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Limmers Bros.				1661- Good Hope Road S.E. Washington, D.C.			
24a. REC'D BY REGISTRAR DATE 15 1957				24b. REGISTRAR'S SIGNATURE Carrie Campbell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 15 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04359

Reg. Dist. No.

nyr

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Washington D.C. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C. 47x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3103 Naylor Road S.E.		d. STREET ADDRESS 3601 Wisconsin Ave., N. W.	
3. NAME OF DECEASED (Type or print) First Middle Last William Melville Counsellor		4. DATE OF DEATH Month Day Year April 12, 19 57.	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Chemical	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME E. M. Counsellor		14. MOTHER'S MAIDEN NAME Elizabeth Diggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 226101070	
17. INFORMANT Julliette Counsellor		Address Washington D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 12, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/57	
22c. NAME OF CEMETERY OR CREMATION Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE APR 17 1957	
		24b. REGISTRAR'S SIGNATURE Carri Campbell	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		SIGNATURE OF WITNESS		DATE		CITY	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF EXAMINER	

BUREAU V. 3

APR 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4356

CERTIFICATE OF DEATH

04360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Maryland		c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Decorato Rest Home			d. STREET ADDRESS 3205 Cheverly Avenue,.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Nellie Adam Davis			4. DATE OF DEATH Month Day Year April 28, 19 57		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 3, 1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maine	
13. FATHER'S NAME Frances Adams			12. CITIZEN OF WHAT COUNTRY? U S A		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			17. INFORMANT Helen D. Bailey Cheverly, Maryland.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atherosclerosis</i> DUE TO (c) <i></i>					INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>2 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Old unhealed fracture of hip, 5 yrs.</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <i>Jan 1957</i> , to <i>27 April 1957</i> , that I last saw the deceased alive on <i>27 April 1957</i> , and that death occurred at <i>Md</i> from the causes and on the date stated above. ADDRESS (Street, city or town, State) DATE SIGNED ACTUAL SIGNATURE <i>John K. Schor</i> M.D. <i>John K. Schor</i> PHYSICIAN'S NAME (Type) <i>Cheverly, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.			24a. REC'D BY REGISTRAR DATE <i>APR 30 1957</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. Smith</i>

CERTIFICATE OF DEATH

STATE OF NEW YORK - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES J. HENRY		M		45		JAN 15 1912		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
MARRIAGE		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY	
MARRIED		JAN 15 1935		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
OCCUPATION		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY	
MANAGER		JAN 15 1935		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
CAUSE OF DEATH		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY	
HEART DISEASE		JAN 15 1957		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
MANNER OF DEATH		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY	
NATURAL		JAN 15 1957		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY	
JAMES J. HENRY		JAN 15 1957		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY	
JAMES J. HENRY		JAN 15 1957		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	

BUREAU V. 3

APR 30 1957

RECEIVED

4357

CERTIFICATE OF DEATH

Reg. Dist. No.

04361

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b 10 Hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General				e. STREET ADDRESS Lestly Ave.			
3. NAME OF DECEASED (Type or print) First Pedro Middle DeCostello Last DeCostello				4. DATE OF DEATH Month April Day 23 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-11-74	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months ?? Days ?? Hours ?? Min. ??		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown				12. CITIZEN OF WHAT COUNTRY? ?? ✓			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary (Wife)		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intercranial hemorrhage DUE TO (c) Cerebral Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 24 hours ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington, D.C.				20g. (County) (State)			
21. I certify that I attended the deceased from April 22 , 19 57 , to April 23 , 19 57 , that I last saw the deceased alive on April 22 , 19 57 , and that death occurred at 2:01 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis Mendel M.D. College Park Md				ADDRESS (Street, city or town, state) 4/25/57			
PHYSICIAN'S NAME (Type) McQueth Conn.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/29/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Hall Bros, 621 Fla Ave NW				ADDRESS 621 Fla Ave NW		24a. REC'D BY REGISTRAR MAY 3 '57	
24b. REGISTRAR'S SIGNATURE W. H. H. H.				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MAY 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4358

CERTIFICATE OF DEATH

Reg. Dist. No.

04362

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 Hyattsville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hosp.</u>				d. STREET ADDRESS <u>14508 Emerson St.</u>			
3. NAME OF DECEASED (Type or print) <u>Clifton Fritter DeWard</u>				4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-98</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
13. FATHER'S NAME <u>Louis Aiden</u>				14. MOTHER'S MAIDEN NAME <u>Rose Fritter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records Riverdale Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO <u>Cardiovascular Renal Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo. 3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 1954</u> to <u>Apr 28, 1957</u> , that I last saw the deceased alive on <u>Apr 28, 1957</u> , and that death occurred at <u>4:45</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md.</u> DATE SIGNED <u>4-28-57</u>			
PHYSICIAN'S NAME (Type) <u>L W Malin, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Sasser</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>James E. Lewis</u> DATE <u>5/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>James E. Lewis</u>	

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
HEART DISEASE		SUICIDE		LABORER		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	
HISTORY OF ILLNESS		TREATMENT		HOSPITAL		PHYSICIAN		NURSE		PATHOLOGIST		FORENSIC		CORONER		BURIAL	
HEART DISEASE		HOSPITAL		HOSPITAL		HOSPITAL		HOSPITAL		HOSPITAL		HOSPITAL		HOSPITAL		HOSPITAL	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	

BUREAU V. 3

MAY 3 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4340

CERTIFICATE OF DEATH

Reg. Dist. No. 245

04363

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 621 Sheridan St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>C</u> Last <u>Eanet</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1899</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store Fictives</u>	
11. BIRTHPLACE (State or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Eanet</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Goldberg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Ruth Eanet</u>		Address <u>621 Sheridan St. Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Premature Myocardial Infarction in July 1952</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>52</u> , to <u>April 3</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>April 3</u> , 19 <u>57</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Dessoff</u> M.D.		ADDRESS (Street, city or town, state) <u>1302-18 St. N.W. Wash. D.C.</u>	
DATE SIGNED <u>4/3/57</u>			
PHYSICIAN'S NAME (Type) <u>SAMUEL DESSOFF</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>King David Hebrew Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Danzansky</u>		23a. ADDRESS <u>99 Sons 3501-14 57 N.W. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>April 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>	

BUREAU V. S.

APR 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04364

4400

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colman Manor</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3903 Colman Manor X 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3903 - Laurence St.</u>				d. STREET ADDRESS <u>3903 - Laurence St.</u>			
3. NAME OF DECEASED (Type or print) <u>ALICE SALLIE ENNIS</u>				4. DATE OF DEATH Month <u>APR</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-95</u>		9. AGE (In years lost birthday) <u>61</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Dye</u>				14. MOTHER'S MAIDEN NAME <u>Lena Ennis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Ellsworth Ennis</u> Address <u>3903 - Laurence St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>4 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH, 1956</u> , to <u>24 APRIL, 1957</u> , that I last saw the deceased alive on <u>22 APRIL, 1957</u> , and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas J. Maloney</u> M.D.				ADDRESS (Street, city or town, state) <u>4814-71st Ave Landover Hills Md 20785</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS G. MALONEY M.D.</u>				DATE SIGNED <u>APR 29 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grace Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Stafford Co. Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber Co. 517-11th St. S.E.</u>				24a. REC'D BY REGISTRAR <u>APR 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

BUREAU V. S.

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 11, 13, 14, Film 0211 4-23-47 et
4359
CERTIFICATE OF DEATH

04365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.				c. LENGTH OF STAY IN 1b 1Hr. 37 Min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Betty Evans				4. DATE OF DEATH Month Day Year April 10 19 57			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-57	9. AGE (In years last birthday) 3 Wks.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Unknown	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mc Ney Wilma (Foster Mother) Same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Parietal subdural hematoma, bilateral DUE TO (c) Intercerebral hemorrhage, right occipital lobe						INTERVAL BETWEEN ONSET AND DEATH 3 hours 3 weeks 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4/10, 1957, to 4/10, 1957, that I last saw the deceased alive on 4/10, 1957, and that death occurred at 11:32 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Perkins				ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville, Md.			
PHYSICIAN'S NAME (Type) Dr. J Perkins				DATE SIGNED 4/13/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 1957		22c. NAME OF CEMETERY OR CREMATORY Prince Georges Land for Burial		22d. LOCATION (City, town, or county) (State) Cheverly, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Perkins				ADDRESS J. Perkins		24a. REC'D BY REGISTRAR APR 17 '57	
				24b. REGISTRAR'S SIGNATURE W. Perkins			

BUREAU V. S.

APR 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4360

04366

Items 8&9 4/30/57 Film G214 GE

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 17 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15542		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 1036 University Blvd. East			
3. NAME OF DECEASED (Type or print) Joseph L. Farren				4. DATE OF DEATH Month April Day 21 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-20-01	
9. AGE (In years last birthday) 55 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Kitt Music Co		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip L. Farren				14. MOTHER'S MAIDEN NAME Florence James			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Helen M. Farren -1036 University Blvd E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 162x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOGENIC CARCINOMA DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 20 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 2, 1957 , to APRIL 21, 1957 , that I last saw the deceased alive on APRIL 21, 1957 , and that death occurred at 6 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel J. N. Sugar		ADDRESS (Street, city or town, state) 4300 KAYWOOD DRIVE DATE SIGNED APRIL 22 1957					
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR M.D.		14T RAINIER, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.				24a. REC'D BY REGISTRAR DATE APR 25 57		24b. REGISTRAR'S SIGNATURE W. H. Hines	

APR 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4361

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04367

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Cheverly Manor			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6325 Kilmer Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle Margaret Last Fitzpatrick				4. DATE OF DEATH Month April Day 21 , Year 19 57 .			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 19, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME James Quill				14. MOTHER'S MAIDEN NAME Johanna Monahan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Address William Fitzpatrick; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 21, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				ADDRESS		24a. REC'D BY REGISTRAR APR 22 '57	
						24b. REGISTRAR'S SIGNATURE Art Leach	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John T. H. Jones		April 19, 1957	
Age		Sex	
65		Male	
Race		Occupation	
White		Retired	
Usual Residence		Place of Death	
Baltimore, Md.		Home	
Cause of Death		Manner of Death	
Coronary Thrombosis		Natural	
Immediate Cause		Contributing Cause	
Myocardial Infarction		Hypertension	
Date of Autopsy		Signature of Examiner	
April 22, 1957		[Signature]	
Hospital or Clinic		Physician	
None		None	
Burial or Disposition		Remarks	
Buried in Baltimore		No further action	

BUREAU V. 3

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04368

Reg. Dist. No.

4362

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN lb 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 212 Oakwood Street S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Milton Middle Freeman Last				4. DATE OF DEATH Month April Day 29 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1895	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy Yard		11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unk.				14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. 256-10-2524		17. INFORMANT Address Carrie L. Freeman Same as # 2 (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Crushed abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 816X DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile that was in an head on collision					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3:19 PM 4/29/1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 301		20f. (City or town) (County) (State) Upper Marlboro P.G. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Noturol causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-3-57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn	
23. FUNERAL DIRECTOR'S SIGNATURE Frager's Funeral Home				24a. REC'D BY REGISTRAR DATE MAY 3 '57		24b. REGISTRAR'S SIGNATURE W. L. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Doe		Male		45		White		May 1, 1957		Home	
Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Physician		Signature of Coroner	
Teacher		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
History of Illness		Post-mortem Examination		Disposition of Body		Disposition of Organs		Disposition of Tissues		Disposition of Bones	
Patient had been ill for several weeks with chest pain and shortness of breath.		No significant findings.		Buried in the family vault.		No organs removed.		No tissues removed.		No bones removed.	
Family History		Social History		Other Remarks		Remarks on Autopsy		Remarks on Toxicology		Remarks on Forensic Pathology	
None.		None.		None.		None.		None.		None.	

RECEIVED
MAY 3 1957
BUREAU V. 1

RECEIVED
MAY 3 1957
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4337

CERTIFICATE OF DEATH

Reg. Dist. No.

04369

230

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>4611 Andrews Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Esther Gordon</u>		4. DATE OF DEATH Month Day Year <u>April 25 1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1872</u>
9. AGE (In years lost birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Indiana</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas A. Mayes</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Duboise</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Myrtella G. Gemeny</u>	
17. INFORMANT <u>Myrtella G. Gemeny</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis - & hardening of arteries</u> DUE TO (c) <u>Ischemic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>13 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 11, 1872</u> , to <u>April 25, 1957</u> , that I last saw the deceased alive on <u>April 25, 1957</u> , and that death occurred at <u>7:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>3701 School St</u> <u>4-25-57</u>			
ACTUAL SIGNATURE <u>J. R. Roedy</u>		M.D. <u>Chen Chow</u>	
PHYSICIAN'S NAME (Type) <u>J. R. Roedy M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-27-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		24a. REC'D BY REGISTRAR <u>APR 30 1957</u>	
ADDRESS <u>4812 66 Ave NW</u>		24b. REGISTRAR'S SIGNATURE <u>John A. Smith</u>	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1,2,5,6,7,9. Film G215 5-15-57 et
4401
CERTIFICATE OF DEATH

04370

Reg. Dist. No.

234

1. PLACE OF DEATH a. COUNTY <u>Prince Geo, MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakeland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakeland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				d. STREET ADDRESS <u>---</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Henry</u> Last <u>Gray</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Approx. 77</u> yrs.	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>		IF UNDER 24 HRS. Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>High blood pressure</u> DUE TO (c) <u>---</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pleurisy</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>6 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 27, 1957</u> to <u>April 28, 1957</u> , that I last saw the deceased alive on <u>April 28, 1957</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. S. Hudson</u> M.D.				DATE SIGNED <u>April 28, 1957</u>			
PHYSICIAN'S NAME (Type) <u>W. S. HUDSON</u>				ADDRESS <u>LAUREL MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/> BURIAL		22b. DATE THEREOF <u>5/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LINCOLN MEMORIAL</u>		22d. LOCATION (City, town, or county) (State) <u>MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest Jarvis Co 1432 7th St NW</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mullin Brackley</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

BUREAU V. 2

MAY 1 1957

RECEIVED

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1912</i></p>	
<p>5. PLACE OF BIRTH <i>Johns Hopkins</i></p>		<p>6. OCCUPATION <i>Physician</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>1935</i></p>	
<p>9. PLACE OF DEATH <i>Johns Hopkins</i></p>		<p>10. CAUSE OF DEATH <i>Myocardial Infarction</i></p>	
<p>11. DATE OF DEATH <i>May 1, 1957</i></p>		<p>12. TIME OF DEATH <i>10:00 AM</i></p>	
<p>13. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>15. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>16. SIGNATURE OF CORONER <i>John Doe</i></p>	



CERTIFICATE OF DEATH

Reg. Dist. No.

245

4363

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2800 Colebrooke Drive, S.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rugene Heland Memorial Hosp.</u>		d. STREET ADDRESS <u>Hillcrest Hts, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Dora</u> Middle <u>Beatrice</u> Last <u>Green</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1897</u> 9. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John William Cook</u>		14. MOTHER'S MAIDEN NAME <u>Phebe Sinclair</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>—</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General arterio sclerosis</u> DUE TO (c) <u>2 wks</u> <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 26, 1957</u> , to <u>Mar 29, 1957</u> , that I last saw the deceased alive on <u>Apr 8, 1957</u> , and that death occurred at <u>1:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malin</u> M.D. <u>Riverdale, Md 4-9-57</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>L.W. Malin, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Transportation</u>	<u>4/10/57</u>	<u>Kansas City</u>	<u>Missouri</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>James E. Hoover</u> 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4341 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Items 8, 9 FilmG214 5-6-57 et

04372

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 23rd and East-West Highway		d. STREET ADDRESS 8108 Tahona Drive	
3. NAME OF DECEASED (Type or print) First Joseph Middle Hais Last		4. DATE OF DEATH Month April Day 4th Year 19 57	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 15, 1890 December 15, 1882
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? Lithuania	
13. FATHER'S NAME Norman Vigderhous		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) : (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Dr. Harry I. Hais; 9518 Biltmore Drive, Springs, Md.		Address Silver	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Md.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) deceased Automobile driven by deceased in collision with another	
20c. TIME OF INJURY Month, Day, Year Hour 10.00 4-4-1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Hyattsville, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. M. loney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. M. loney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 4, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/5/57	
22c. NAME OF CEMETERY OR CREMATORY Adas Israel		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Dargatzsky + Sons - 3501 14th St. N.W.		24a. REC'D BY REGISTRAR April 6 1957	
24b. REGISTRAR'S SIGNATURE Mrs. Jas. S. Sere		24c. REGISTRAR'S SIGNATURE Refusely	

STATE OF NEW YORK MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Joseph		Male		40	
Race		Color		Birthplace	
White		White		New York	
Married		Profession		Occupation	
Married		Grocery		Unknown	
Cause of Death		Manner of Death		Place of Death	
Two Vascular		Accident		Home	
T. Henry J. Smith, M.D.		J. Henry J. Smith, M.D.		J. Henry J. Smith, M.D.	

Crushed chest
Pneumonia and shock

Recorded in
Monopolized driven by KERNANX in collision with another
Hawthorne, N.Y.
J. Henry J. Smith, M.D.

BUREAU V. 2

APR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4402

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04373

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville c. LENGTH OF STAY IN 1b Transient d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 50(new) near 301				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lincoln Park 59x-3 d. STREET ADDRESS 1968 Regina Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Robert Haley		4. DATE OF DEATH Month April Day 7 Year 1957		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 7/26/33 9. AGE (In years last birthday) 23 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airman 10b. KIND OF BUSINESS OR INDUSTRY U. S. Airforce 11. BIRTHPLACE (State or foreign country) Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Francis Haley 14. MOTHER'S MAIDEN NAME Ethel Alberta Landyunt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. In now 17. INFORMANT U. S. Airforce Records, U.S. Airforce Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 822x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compound fracture of the skull, crushed chest and (c) abdomen							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) over Occupant of an automobile that got out of control and turned/					
20c. TIME OF INJURY Month, Day, Year How 4:45 a.m. 4/7/ 1957 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) New Rt # 50 20f. (City or town) Mitchellville P. G. (County) Md. (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 7, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park, Michigan			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. ADDRESS 517-11 St. J. E.		24a. REC'D BY REGISTRAR APR 11 1957 DATE		24b. REGISTRAR'S SIGNATURE Regina Young			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
James Thomas Kelly		Male		38		April 11, 1957	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
U.S. Air Force		U.S. Air Force		Complications of the skull, crushed skull and compound fracture of the skull, crushed skull and compound fracture of the skull		Accident	
Occupation		Education		Marital Status		Social History	
U.S. Air Force		High School		Single		No	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

APR 11 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly,				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Helen Middle C. Last Hansen				4. DATE OF DEATH Month April Day 3 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10- 1898	9. AGE (In years last birthday) yrs. 59	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William W. Phelps				14. MOTHER'S MAIDEN NAME Capitola Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT H A Hansen Bowie, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, left. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 weeks YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) 4300 Kaywood Drive		(County) (State)	
21. I certify that I attended the deceased from April 2, 19 57 , to April 3, 19 57 , that I last saw the deceased alive on April 3, 19 57 , and that death occurred at 9:00P M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon R. Levitsky M.D.				ADDRESS (Street, city or town, state) 4300 Kaywood Drive Mt. Rainier, Md			
DATE SIGNED 4/5/57							
PHYSICIAN'S NAME (Type) Dr. Leon Levitsky				4300 Kaywood Drive Mt. Rainier, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/57		22c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Collington Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE APR 6 57		24b. REGISTRAR'S SIGNATURE Quincy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4365 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 2301 Tacoma Street			
3. NAME OF DECEASED (Type or print) Roland Royland First Middle Last				4. DATE OF DEATH April Month Day Year 16, 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-3-09	
9. AGE (In years this birthday) 47 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane operator		10b. KIND OF BUSINESS OR INDUSTRY construction		11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mansfield Harrah				14. MOTHER'S MAIDEN NAME Susie Adkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 228-09-7091		17. INFORMANT Address Edith Harrah; same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9123 DUE TO Compression of chest and abdomen Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO Bulldozer falling on body and pinning him beneath (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A bulldozer that was being driven onto a truck by deceased flipped over backwards pinning him beneath.					
20c. TIME OF INJURY Hour 6:45 p. m. Month 4 Day 16 Year 57		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Greenbelt		20f. (City or town) (County) (State) Greenbelt, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 17, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-20-57		22c. NAME OF CEMETERY OR CREMATORY LONDON PARK		22d. LOCATION (City, town, or county) (State) BALTIMORE Md	
23. FUNERAL DIRECTOR'S SIGNATURE George R. Schwalb				24a. REC'D BY REGISTRAR APR 22 57		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. For: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of deceased		Sex		Age	
John Doe		Male		35	
Race		Color		Date of death	
White		White		April 22, 1957	
Place of death		Cause of death		Manner of death	
St. Louis, Mo.		Heart disease		Natural	
Residence		Occupation		Signature of physician	
1234 Main St.		Teacher		J. Doe, M.D.	
City		County		State	
St. Louis		St. Louis		Missouri	
Date of birth		Place of birth		Signature of medical examiner	
April 1, 1922		St. Louis, Mo.		J. Doe, M.D.	
Date of death		Place of death		Signature of medical examiner	
April 22, 1957		St. Louis, Mo.		J. Doe, M.D.	

Compression of chest and abdomen
All over falling on body and planning his person
A physician that was called upon to see him
over the chest and abdomen.

BUREAU V. 2

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04376

Reg. Dist. No.

224

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) — a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>			c. LENGTH OF STAY IN lb <u>10 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Xo Hillside</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1223 48th Avenue</u>				d. STREET ADDRESS <u>/ 1223 48th Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Robert Hudson</u>				4. DATE OF DEATH Month Day Year <u>April 25, 19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 1864</u>	
9. AGE (In years last birthday) <u>92 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Piano finisher</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>England</u>			
13. FATHER'S NAME <u>Charles Hudson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Tim</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mrs Edith Hudson same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				DATE SIGNED <u>April 25, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-27-57 Lee's Crematorium - Wash DC</u>		22b. DATE THEREOF <u>4-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>		22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - A</u>				ADDRESS <u>APR 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. N.

1957 29 177

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2,9 Film 215 5-10-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

04377

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>				c. LENGTH OF STAY IN 1b <u>2-YRS-</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anna Mae</u> First Middle Last <u>JENKINS</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 1, 1888</u>	
9. AGE (In years last birthday) <u>68 1/2</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>James Henry Han-</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Rankin Harn-</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Ronald W. Jenkins</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4341 Congestive heart failure</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4-13-1957</u> to <u>4-30-1957</u> that I last saw the deceased alive on <u>4-30-1957</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David S. Gordon</u> M.D. <u>5731 23rd Parkway SE</u>				DATE SIGNED <u>57</u>			
PHYSICIAN'S NAME (Type) <u>DAVID S. GORDON, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 3-1957</u>		<u>Fort Lincoln</u>		<u>Calver Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee's Son & Son</u> ADDRESS <u>W. Wash D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE</u> 24b. REGISTRAR'S SIGNATURE <u>6 MAY 6 1957</u>			

MAY 6 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom card may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04378

4405 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Prince George</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Prince George</i>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ridgeway Estates</i>		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Switland</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>15 Weber Drive</i>				STREET ADDRESS (If rural give location) <i>3202 Logan St.</i>			
3. NAME OF DECEASED (Type or Print) <i>BRADLEY Thomas Johnson, SR.</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>April 17, 1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widower</i>	8. DATE OF BIRTH <i>Jan 4, 1873</i>	9. AGE last birthday <i>84</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Street Lighting</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>PEPCO-</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>400</i>		17. INFORMANT & ADDRESS <i>Bradley J. Johnson Jr. Son</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
446X IMMEDIATE CAUSE (A) <i>Renal Insufficiency (Uremia)</i>						<i>1 yr.</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Renal Arterio Sclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>260x Pluritic Medulla</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 1957</i> , to <i>April 17, 1957</i> , that I last saw the deceased alive on <i>April 16, 1957</i> , and that death occurred at <i>4:00 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Edward A. Galant</i> M.D.				ADDRESS (Street, city, town, state) <i>5203 S. 16th St. R.D. 5</i>		DATE SIGNED <i>4/17/57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>April 20, 1957</i>		NAME OF CEMETERY OR CREMATORY <i>Washington National</i>		LOCATION (City, town, or county) (State) <i>Switland, Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>d. J. Dedwich</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co. Washington, D.C.</i>			
DATE <i>APR 22 1957</i>							

1. The first step is to identify the problem or question that needs to be addressed. This involves understanding the context and the specific requirements of the task.

BUREAU V. E.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04379

4342

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Bell Nursing Home</u>				d. STREET ADDRESS <u>Aeger Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ann Louise Jones</u>				4. DATE OF DEATH Month Day Year <u>April 6, 19 57.</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1956</u>		9. AGE (In years last birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Griffith Jones</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Bell Nursing Home Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute upper respiratory infection</u> <u>754.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septicemia</u> (c) <u>Morphine - congenital heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 hours</u> <u>from birth</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7/15</u> , 19 <u>56</u> , to <u>4/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/6</u> , 19 <u>57</u> , and that death occurred at <u>4:55</u> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>College Park, Md 4/6/57</u>			
PHYSICIAN'S NAME (Type) <u>Thomas A. Christensen</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				ADDRESS		24a. RECEIVED BY REGISTRAR DATE <u>APR 11 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>James George</u>			

BUREAU V. S.

APR 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04380

4366

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Caroll Middle Jones Last Jones		4. DATE OF DEATH Month April Day 21 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-10-11
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Jones		14. MOTHER'S MAIDEN NAME Janie Lancaster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Jones, Jr.		Address 521 Swann Street, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident . DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 21, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 4-25-57	22c. NAME OF CEMETERY OR CREMATORY Queens Chapel	22d. LOCATION (City, town, or county) (State) Mount Airy Md
23. FUNERAL DIRECTOR'S SIGNATURE Sammy L. Washington		ADDRESS Sno 467 N. 4th St	
24a. REC'D BY REGISTRAR DATE 24 1957		24b. REGISTRAR'S SIGNATURE James L. ...	

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION & WELFARE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
William Jones		Male		45		April 24, 1957	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Lancaster, Pennsylvania		Lancaster, Pennsylvania		Heart Disease		Natural	
Occupation		Education		Marital Status		Previous Illnesses	
Engineer		High School		Married		None	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. E.

APR 24 1957

RECEIVED

4496
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (Rural)				c. LENGTH OF STAY IN 1b 2 months, 25 days/			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Washington 47x-3			
d. STREET ADDRESS 445 Franklin St., N.W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fred Middle Last Jones				4. DATE OF DEATH Month April Day 17 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ruff Jones				14. MOTHER'S MAIDEN NAME Kitty Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Lost		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma of the esophagus with 150x DUE TO metastasis to ribs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Pulmonary tuberculosis, 6 months							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from January 23, 1957, to April 17, 1957, that I last saw the deceased alive on April 17, 1957, and that death occurred at 2:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Moe Weiss M.D. Glenn Dale Hospital, Glenn Dale, Md. 4/17/57 PHYSICIAN'S NAME (Type) Moe Weiss							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 4/18/57		22c. NAME OF CEMETERY OR CREMATORY ✓		22d. LOCATION (City, town, or county) (State) ✓	
23. FUNERAL DIRECTOR'S SIGNATURE Malvan & Schey Inc Sherwood B Fisher				ADDRESS 424 R St NW		24a. REC'D BY REGISTRAR DATE 24b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4343

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nyattsville Rest House</u>		d. STREET ADDRESS <u>1228 Eye St. NW</u>	
3. NAME OF DECEASED (Type or print) First <u>HYMAN</u> Middle <u>KLEIN</u> Last <u>KLEIN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? Avigdor Hersh</u>		14. MOTHER'S MAIDEN NAME <u>? Shaine Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>195-07-3734</u>	
17. INFORMANT <u>Ellis Klein Son 1228 Eye St. NW</u>		Address <u>1228 Eye St. NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Hypostatic pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>March 1956</u> Hour <u>11:45</u> a.m. <u>PM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1956</u> , to <u>April 7, 1957</u> , that I last saw the deceased alive on <u>April 7, 1957</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>3008-14th N.W. Wash. D.C.</u>		DATE SIGNED <u>4/8/57</u>	
ACTUAL SIGNATURE <u>Harold F. McCann</u> M.D.			
PHYSICIAN'S NAME (Type) <u>HAROLD F. MCCANN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/9-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Mem Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Nyattsville MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash DC</u>		24a. REC'D BY REGISTRAR <u>April 10, 1957</u>	
ADDRESS <u>Wash DC</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe Deputy.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04383

4477

CERTIFICATE OF DEATH

Reg. Dist. No.

247

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5959 Rollins Ave.</u>				d. STREET ADDRESS <u>5979 Rollins Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>CECELIA</u> Last <u>KLOTZ</u>				4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 30, 1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Roussillon</u>				14. MOTHER'S MAIDEN NAME <u>Marie Chalambeau</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Marie Lanaburg 5959 Rollins Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Embolism</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u> <u>15 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1942</u> to <u>April 5, 1957</u> , that I last saw the deceased alive on <u>April 5, 1957</u> , and that death occurred at <u>3:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainin</u> M.D.				ADDRESS (Street, city or town, state) <u>6124 Central Ave</u> DATE SIGNED <u>4/5/57</u>			
PHYSICIAN'S NAME (Type) <u>WM. BRAININ</u>				Capitol Heights Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suit Land Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Wm Lee & Sons Co. 300 4th St. N.E. Wash. D.C.</u>				24a. RECEIVED BY REGISTRAR DATE <u>APR 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04384

4408

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Kentucky Ave, Parkland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkland, X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 25 Kentucky Ave.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MRS. HELEN VIRGINIA KOBER				4. DATE OF DEATH APRIL 8 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6, 1894	
9. AGE (In years last birthday) 62 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Hiram Walty				14. MOTHER'S MAIDEN NAME Gertrude Suite			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Paul M. Kober, son, 25 Kentucky Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIO-RESPIRATORY FAILURE 204.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC MYELOID LEUKEMIA DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 14Y. 4YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JAN. 12, 1957 , to APRIL 8, 1957 , that I last saw the deceased alive on APRIL 5, 1957 , and that death occurred at 2:57 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7200 MARLBORO RD. DATE SIGNED ACTUAL SIGNATURE John E. Ford M.D. DISTRICT HEIGHTS, MD. PHYSICIAN'S NAME (Type) JOHN E. FORD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 11, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson				ADDRESS Wash. D.C. 1300-N St. N.W.		24a. REC'D BY REGISTRAR DATE APR 10 57	
24b. REGISTRAR'S SIGNATURE W. H. ...							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

X

X

CHRONIC MYELOID LEUKEMIA
ACUTE CHRONIC-RESPIRATORY FAILURE INT.

BUREAU V. 2

2500 MARLBORO RD
APR 10 1957

DISTRICT REPORTS, MD.
RECEIVED

JOHN C. FORD
APRIL 2 1957
2029

John C. Ford

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4409

CERTIFICATE OF DEATH

Reg. Dist. No.

04385

245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rum-Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> 34			
c. LENGTH OF STAY IN 1b <u>1 year</u>				d. STREET ADDRESS <u>4012 Bunker Hill Rd</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paint Branch Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Myrtle</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rooming House Operator - Same</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Pounds</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Gutridge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>1703 Allen 4012 Bunker Hill Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>12 hour</u> <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 1, 1956</u> , to <u>April 1, 1957</u> , that I last saw the deceased alive on <u>March 25, 1957</u> , and that death occurred at <u>8:00 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Whitbeck</u> M.D.				ADDRESS (Street, city or town, state) <u>7701 Carroll Ave 4-1-57</u>			
PHYSICIAN'S NAME (Type) <u>Takoma Park 12 Md</u>				DATE SIGNED <u>APR 4 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Wash. D.C.</u>				ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>APR 4 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>James Seaver</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		HISTORICAL FACTS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 5

APR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05492

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo District Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Genral Hospital		d. STREET ADDRESS 7705 Alpine St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Girl Lewis		4. DATE OF DEATH Month April Day 29 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 April 1957
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Lewis		14. MOTHER'S MAIDEN NAME Geraldine Anne Moreau	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/28, 1957, to 4/29, 1957, that I last saw the deceased alive on 4/28, 1957, and that death occurred at 1,30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>Aaron Ditz</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
24a. REC'D BY REGISTRAR DATE MAY 10 1957		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

2077181XVO

BUREAU V. S.

MAY 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4344 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04386

Reg. Dist. No. *245*

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville			c. LENGTH OF STAY IN 1b transient			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colesville Road				d. STREET ADDRESS 3305 Rutgers Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Robert Middle Paul Last Long				4. DATE OF DEATH Month April Day 14 Year 19 57				
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1947		
9. AGE (In years last birthday) 9 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School-boy			10b. KIND OF BUSINESS OR INDUSTRY None, Minor, Child		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Walter Long				14. MOTHER'S MAIDEN NAME Irene Grindle Grindle				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Irene Long Address 3305 Rutgers St., Hyattsville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 929.8 DUE TO Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 929.8 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell into a well through a hole in the floor of the covered				
20c. TIME OF INJURY Month, Day, Year 1.00 Hour 4-14- 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Private estate		20f. (City or town) (County) house (State) W. Hyattsville, Pr. Geo. Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 14, 1957				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem.		22d. LOCATION (City, town, or county) (State) Neat Barton, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE APR 22 1957 24b. REGISTRAR'S SIGNATURE <i>James Jones</i>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded by the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Place of Birth	
John Doe		Boston, Mass.	
Age		Sex	
45		Male	
Date of Death		Cause of Death	
Jan. 15, 1957		Heart Disease	
Place of Death		Occupation	
Home		Teacher	
Signature of Physician		Signature of Medical Examiner	
[Signature]		[Signature]	

all into a well through a hole in the floor of the covered

BUREAU A. 3

Jan 22 1957

RECEIVED

MEDICAL CERTIFICATION

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04388

4368

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. RAINIER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GENERAL HOSPITAL		d. STREET ADDRESS 3300 OTIS ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLAUDE Middle R. MASON Last		4. DATE OF DEATH Month APRIL / Day 13 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-97
9. AGE (In years lost birthday) 60 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Street Sup. Wash. Gas Light Co.		10b. KIND OF BUSINESS OR INDUSTRY W. Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Mason		14. MOTHER'S MAIDEN NAME Rosa Hayes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Chloe Melintz		Address 3511 Davenport St. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RHEUMATIC HEART DISEASE WITH MITRAL STENOSIS 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SEVERE FATTY METAMORPHOSIS WITH EARLY SCARRING DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/10 , 19 57 , to 13 APRIL , 19 57 , that I last saw the deceased alive on 12 , and that death occurred at 4:25 AM , from the causes and on the date stated above. By Dr. George Hageage ACTUAL SIGNATURE Paul J. Oviatt M.D. ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) GEORGE HAGEAGE 3717 38th Avenue, Cottage City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-16-57	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	22d. LOCATION (City, town, or county) (State) Prince Georges Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co		24a. REC'D BY REGISTRAR APR 17 57	
ADDRESS 2901-14th St. N.W.		24b. REGISTRAR'S SIGNATURE W. Beach	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. DATE OF MARRIAGE [REDACTED]</p>	
<p>9. NAME OF SPOUSE [REDACTED]</p>		<p>10. DATE OF DEATH [REDACTED]</p>	
<p>11. PLACE OF DEATH [REDACTED]</p>		<p>12. CAUSE OF DEATH [REDACTED]</p>	
<p>13. MEDICAL HISTORY [REDACTED]</p>		<p>14. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>15. SIGNATURE OF DECEASED [REDACTED]</p>		<p>16. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>17. SIGNATURE OF DECEASED [REDACTED]</p>		<p>18. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>19. SIGNATURE OF DECEASED [REDACTED]</p>		<p>20. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>21. SIGNATURE OF DECEASED [REDACTED]</p>		<p>22. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>23. SIGNATURE OF DECEASED [REDACTED]</p>		<p>24. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>25. SIGNATURE OF DECEASED [REDACTED]</p>		<p>26. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>27. SIGNATURE OF DECEASED [REDACTED]</p>		<p>28. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>29. SIGNATURE OF DECEASED [REDACTED]</p>		<p>30. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>31. SIGNATURE OF DECEASED [REDACTED]</p>		<p>32. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>33. SIGNATURE OF DECEASED [REDACTED]</p>		<p>34. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>35. SIGNATURE OF DECEASED [REDACTED]</p>		<p>36. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>37. SIGNATURE OF DECEASED [REDACTED]</p>		<p>38. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>39. SIGNATURE OF DECEASED [REDACTED]</p>		<p>40. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>41. SIGNATURE OF DECEASED [REDACTED]</p>		<p>42. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>43. SIGNATURE OF DECEASED [REDACTED]</p>		<p>44. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>45. SIGNATURE OF DECEASED [REDACTED]</p>		<p>46. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>47. SIGNATURE OF DECEASED [REDACTED]</p>		<p>48. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>49. SIGNATURE OF DECEASED [REDACTED]</p>		<p>50. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>51. SIGNATURE OF DECEASED [REDACTED]</p>		<p>52. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>53. SIGNATURE OF DECEASED [REDACTED]</p>		<p>54. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>55. SIGNATURE OF DECEASED [REDACTED]</p>		<p>56. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>57. SIGNATURE OF DECEASED [REDACTED]</p>		<p>58. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>59. SIGNATURE OF DECEASED [REDACTED]</p>		<p>60. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>61. SIGNATURE OF DECEASED [REDACTED]</p>		<p>62. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>63. SIGNATURE OF DECEASED [REDACTED]</p>		<p>64. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>65. SIGNATURE OF DECEASED [REDACTED]</p>		<p>66. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>67. SIGNATURE OF DECEASED [REDACTED]</p>		<p>68. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>69. SIGNATURE OF DECEASED [REDACTED]</p>		<p>70. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>71. SIGNATURE OF DECEASED [REDACTED]</p>		<p>72. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>73. SIGNATURE OF DECEASED [REDACTED]</p>		<p>74. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>75. SIGNATURE OF DECEASED [REDACTED]</p>		<p>76. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>77. SIGNATURE OF DECEASED [REDACTED]</p>		<p>78. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>79. SIGNATURE OF DECEASED [REDACTED]</p>		<p>80. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>81. SIGNATURE OF DECEASED [REDACTED]</p>		<p>82. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>83. SIGNATURE OF DECEASED [REDACTED]</p>		<p>84. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>85. SIGNATURE OF DECEASED [REDACTED]</p>		<p>86. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>87. SIGNATURE OF DECEASED [REDACTED]</p>		<p>88. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>89. SIGNATURE OF DECEASED [REDACTED]</p>		<p>90. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>91. SIGNATURE OF DECEASED [REDACTED]</p>		<p>92. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>93. SIGNATURE OF DECEASED [REDACTED]</p>		<p>94. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>95. SIGNATURE OF DECEASED [REDACTED]</p>		<p>96. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>97. SIGNATURE OF DECEASED [REDACTED]</p>		<p>98. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>99. SIGNATURE OF DECEASED [REDACTED]</p>		<p>100. SIGNATURE OF WITNESS [REDACTED]</p>	

BUREAU V. S.

APR 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4412

CERTIFICATE OF DEATH

04391

Reg. Dist. No.

739

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bowie - Laurel Rd.</u>		d. STREET ADDRESS <u>Bowie Laurel Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Billy Marie</u> First Middle Last		4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1912</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Independence, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank M. Babbitt</u>		14. MOTHER'S MAIDEN NAME <u>Maudie Edwards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Edward E. Merkel, Laurel Md</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer</u> DUE TO <u>5 yrs</u> (b) <u>Carcinoma Breast</u> DUE TO <u>6 yrs</u> (c) <u>S cirrhosis Carcinoma</u> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/10</u> , 19 <u>57</u> , to <u>4/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/20/57</u> , 19 <u>57</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Laurel</u> DATE SIGNED <u>4/24/57</u>			
ACTUAL SIGNATURE <u>J M Warren</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOHN M. WARREN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery Highland Md</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Chandler, Laurel Md</u>		24a. REC'D BY REGISTRAR <u>APR 24 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mollie Bruckner</u>	

WASH. STATE DEPARTMENT OF HEALTH—BACUPCORE 15

BUREAU A. S.

APR 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04389

Reg. Dist. No.

734

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington D. C. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C. 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 210		d. STREET ADDRESS 2759 Nichols avenue S. E.	
3. NAME OF DECEASED (Type or print) First Herbert Middle Asbury Last Michael		4. DATE OF DEATH Month April Day 12th Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 20, 1925
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months 32 Days 32 Hours 32 Min. 32	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic Capital Air Lines		11b. KIND OF BUSINESS OR INDUSTRY West Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Charles E. Michael	
14. MOTHER'S MAIDEN NAME Zourie C. Grove		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Norman E. Michael		17. INFORMANT 3758 W Street N W Washington D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of the skull, crushed abdomen and chest (c) Compound comminuted fracture of both legs, fractures of both forearms PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Occupant of an automobile that ran of the road and struck / tree			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that ran of the road and struck / tree		20c. TIME OF INJURY Month, Day, Year 4/ 11 57 Hour 11:50 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 211	
20f. (City or town) Accokeek		20g. (County) P. G.	
20h. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 16- 57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		24a. REC'D BY REGISTRAR Carrie Campbell	
24b. REGISTRAR'S SIGNATURE Carrie Campbell		24c. DATE APR 15 1957	

RECEIVED

APR 15 1957

BUREAU V. 3

Accord

to house

W 11 32

11:30

Two of the small, round, brown and green
Government of United States of America, two
of both families

He then said that

11

11:30

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4369

CERTIFICATE OF DEATH

04390

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly Md.		c. LENGTH OF STAY IN 1b 5 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. STREET ADDRESS 11110 Montgomery Road	
3. NAME OF DECEASED (Type or print) Baby Girl (Bonnie E. Miller)		4. DATE OF DEATH April 25 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-57
9. AGE (In years last birthday) 5 days		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Noland P Miller		14. MOTHER'S MAIDEN NAME Dorothy Knauer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT Noland P Miller		Address Beltsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 759.3 Acute mediastinitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured Esophageal anastomosis DUE TO (c) Repair of Esophageal atresia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 19 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) College Park, Md. DATE SIGNED 4/26/57 ACTUAL SIGNATURE Thomas A. Christensen M.D. PHYSICIAN'S NAME (Type) Dr. Ware & Dr. Christenson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/57	
22c. NAME OF CEMETERY OR CREMATORY Trinity Church Cemetery		22d. LOCATION (City, town, or county) (State) Bowie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE APR 30 57	
24b. REGISTRAR'S SIGNATURE Overman			

2177421XV3

APR 30 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halls		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 301			d. STREET ADDRESS 3545 Greenmount Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Benjamin Mouery			4. DATE OF DEATH Month Day Year April 27 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1924	9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Bethesda, Md.	
13. FATHER'S NAME Charles Mouery			14. MOTHER'S MAIDEN NAME Ida Cusic		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. In service		17. INFORMANT Papers on person Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed abdomen DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile that ran off road and turned over			
20c. TIME OF INJURY Month, Day, Year 3:12 p. m. 4/27/1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 301	20f. (City or town) Hall	(County) Pr. Geo.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 27, 1957	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 4/27/57	22c. NAME OF CEMETERY OR CREMATORY Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.		ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE APR 30 1957	24b. REGISTRAR'S SIGNATURE O. W. Heath

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WESTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
APR 30 1957
BUREAU V. S.

4414

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook Acres</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook Acres, Md x 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9404 - Tuckerman St</u>				d. STREET ADDRESS <u>9404 Tuckerman ST 1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Scorge</u> Middle <u>ROBERT</u> Last <u>Mullinix</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 12, 1902</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Esso Standard Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>George Ellsworth Mullinix</u>				14. MOTHER'S MAIDEN NAME <u>Emma Virginia Burdette</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Agnes F Mullinix</u>				Address <u>Seabrook Acres Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion with acute infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Several years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>55</u> , to <u>April 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 20</u> , 19 <u>57</u> and that death occurred at <u>3:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. James Kurtz</u>				M.D. <u>RFD Bowie</u>			
PHYSICIAN'S NAME (Type) <u>H. James Kurtz</u>				DATE SIGNED <u>md 4/21/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. G. G. some Hyattsville Md</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>APR 22 1957</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM

BUREAU V. S.

APR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4370

CERTIFICATE OF DEATH

04394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Claude</u> Middle <u>N</u> Last <u>Norton</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 29, 1889</u> 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARCHITECT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE, CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM E NORTON</u>		14. MOTHER'S MAIDEN NAME <u>MARY E SITTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>4002 Crittenden St</u>	
17. INFORMANT <u>Claude R Norton</u> Address <u>Hyatts, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Biliary cirrhosis</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of stomach - metastases</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>3/14</u> , 19 <u>57</u> to <u>4/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>57</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Howard S. Madigan</u> M.D. <u>6480 New Hampshire Ave.</u>		ADDRESS (Street, city or town, state) _____ DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>Howard S. Madigan, M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
22b. DATE THEREOF <u>4-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>	
22d. LOCATION (City, town, or county) <u>Wash, D. C.</u> (State) _____		23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u> ADDRESS <u>1400 Chapin St NW</u>	
24a. REC'D BY REGISTRAR <u>DATE 4/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>A. W. Keuch</u>	

[The page contains faint, illegible text, likely bleed-through from the reverse side.]

BUREAU V. 8

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04395

Reg. Dist. No.

4371

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Camden			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 1 Hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pennsauken	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hosp.				d. STREET ADDRESS 7502 Rogers Ave			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MICHAEL JOSEPH OFFENBACHER				4. DATE OF DEATH April 22 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 Oct. 1953		9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hurley F. Offenbacher				14. MOTHER'S MAIDEN NAME Patricia A. Lerner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Patricia A. Offenbacher Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fractured skull DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child was struck by an automobile while crossing street.					
20c. TIME OF INJURY Hour 4:59 AM 4-2-57	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) Beltsville	(County) Pr. Geo. Md.	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 2, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		4-5-1957		Waco, D.C.		Waco, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly				ADDRESS 131-11th St		24a. REC'D BY REGISTRAR James Hoover	
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
George J. ...		21		Male		Caucasian	
Date of Death		Place of Death		Cause of Death		Manner of Death	
April 4, 1957		Boston, Mass.		Sudden		Natural	
Occupation		Education		Marital Status		Previous Illnesses	
None		High School		Single		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

Child was struck by an automobile while crossing street.

Investigation conducted by ...

Witnesses interviewed ...

Autopsy performed ...

Disposition of body ...

Remarks ...

John F. ...

RECEIVED

BUREAU V. 3

APR 4 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04396

Reg. Dist. No.

4372

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1119 57th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Andrew Middle Carnegie Last Palmer				4. DATE OF DEATH Month April Day 8 Year 19 57			
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 12, 1907	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 4 Days 9		IF UNDER 24 HRS. Hours 19 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ulysses Palmer				14. MOTHER'S MAIDEN NAME Cordee Patrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Zenorra Palmer; same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Atherosclerosis (c) Cardiovascular renal disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of liver.							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-13-57		22c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL		22d. LOCATION (City, town, or county) (State) SUITLAND, P.G. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Toney</i>				ADDRESS 414-15th S.E.		24a. REC'D BY REGISTRAR APR 12 1957	
				24b. REGISTRAR'S SIGNATURE <i>Overman</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 12 1957

BUREAU V. 2

Seniors; right; same address

Corbin, Corbin

Corbin, Corbin

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4345

CERTIFICATE OF DEATH

Reg. Dist. No.

04397

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3808 Nicholson St				d. STREET ADDRESS 3808 Nicholson St			
3. NAME OF DECEASED (Type or print) LILLIE First Middle PARISH Last				4. DATE OF DEATH Month April Day 7 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25, 1882		9. AGE (In years last birthday) yrs. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel Tubbs				14. MOTHER'S MAIDEN NAME ? Lynch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Norman J. Parish Address 6001 44th ave Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension & arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH 5 min. 10 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-25-1957 to 4-7-1957, that I last saw the deceased alive on 4-7-1957, and that death occurred at 5:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.D. Bauer M.D.				ADDRESS (Street, city or town, state) 2513 Brookridge Rd. Delphi, Md.			
DATE SIGNED 4-7-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE APR 11 1957		24b. REGISTRAR'S SIGNATURE James L. Reeves	

RECEIVED

BUREAU V. S.

APR 11 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
44 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04398

Reg. Dist. No.

24 &

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10 Arcey Road (Box 27)</u>				d. STREET ADDRESS <u>10 Arcey Road (Box 27)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Henry Pinkney</u>				4. DATE OF DEATH Month Day Year <u>April 3 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 1901</u>	
9. AGE (In years last birthday) <u>55 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John Pinkney</u>				14. MOTHER'S MAIDEN NAME <u>Susie Spriggs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>46-57</u>		17. INFORMANT <u>Elinor Barnett</u> Address <u>10 Arcey Road, Forestville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x blepharitis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-6-57</u>				22b. DATE THEREOF <u>4-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	
22d. LOCATION (City, town, or county) (State) <u>Cammy Rd SE DC</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L Washington</u>				ADDRESS <u>467 Nat. Ave</u>		24a. REC'D BY REGISTRAR <u>APR 12 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>							

DATE SIGNED

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

April 3, 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF CLERK		22. SIGNATURE OF NURSE		23. SIGNATURE OF DOCTOR		24. SIGNATURE OF PHARMACEUTICAL		25. SIGNATURE OF LABORATORY	
26. SIGNATURE OF PATHOLOGIST		27. SIGNATURE OF RADIOLOGIST		28. SIGNATURE OF ANATOMIST		29. SIGNATURE OF HISTOLOGIST		30. SIGNATURE OF MICROSCOPIC	
31. SIGNATURE OF BACTERIOLOGIST		32. SIGNATURE OF VIROLOGIST		33. SIGNATURE OF PARASITOLOGIST		34. SIGNATURE OF ENTOMOLOGIST		35. SIGNATURE OF ZOOLOGIST	
36. SIGNATURE OF BOTANIC		37. SIGNATURE OF AGRICULTURIST		38. SIGNATURE OF FISHERMAN		39. SIGNATURE OF HUNTER		40. SIGNATURE OF TRAPPER	
41. SIGNATURE OF MINER		42. SIGNATURE OF MILLER		43. SIGNATURE OF TANNER		44. SIGNATURE OF COOPER		45. SIGNATURE OF CARPENTER	
46. SIGNATURE OF JOINER		47. SIGNATURE OF PAINTER		48. SIGNATURE OF GLAZIER		49. SIGNATURE OF ROOFER		50. SIGNATURE OF PLUMBER	
51. SIGNATURE OF ELECTRICIAN		52. SIGNATURE OF MECHANIC		53. SIGNATURE OF BLACKSMITH		54. SIGNATURE OF WHEELWRIGHT		55. SIGNATURE OF SADDLERY	
56. SIGNATURE OF SHOE REPAIRER		57. SIGNATURE OF JEWELER		58. SIGNATURE OF OPTICIAN		59. SIGNATURE OF BARBER		60. SIGNATURE OF TAILOR	
61. SIGNATURE OF HATTER		62. SIGNATURE OF MILLINER		63. SIGNATURE OF BOOKBINDER		64. SIGNATURE OF STATIONER		65. SIGNATURE OF PRINTER	
66. SIGNATURE OF PUBLISHER		67. SIGNATURE OF EDITOR		68. SIGNATURE OF WRITER		69. SIGNATURE OF ACTRESS		70. SIGNATURE OF MUSICIAN	
71. SIGNATURE OF DANCER		72. SIGNATURE OF SINGER		73. SIGNATURE OF COMEDIAN		74. SIGNATURE OF CLERGYMAN		75. SIGNATURE OF MINISTER	
76. SIGNATURE OF RABBI		77. SIGNATURE OF PRIEST		78. SIGNATURE OF BISHOP		79. SIGNATURE OF CARDINAL		80. SIGNATURE OF POPE	
81. SIGNATURE OF MONK		82. SIGNATURE OF NUN		83. SIGNATURE OF PRIOR		84. SIGNATURE OF ABBOT		85. SIGNATURE OF SUPERIOR	
86. SIGNATURE OF CONVENT		87. SIGNATURE OF MONASTERY		88. SIGNATURE OF CATHEDRAL		89. SIGNATURE OF PARISH		90. SIGNATURE OF CHURCH	
91. SIGNATURE OF SYNAGOGUE		92. SIGNATURE OF MOSQUE		93. SIGNATURE OF TEMPLE		94. SIGNATURE OF CHAPEL		95. SIGNATURE OF ALTAR	
96. SIGNATURE OF PULPIT		97. SIGNATURE OF ALTAR		98. SIGNATURE OF CHANCEL		99. SIGNATURE OF TRANCHE		100. SIGNATURE OF CHORUS	

BUREAU V. 3

APR 12 1957

RECEIVED

4373

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASH. 28			
c. LENGTH OF STAY IN 1b 13 Days				d. STREET ADDRESS 1011 COUNTY RD. S.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE'S GEN. HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BESSIE Middle VIRGINIA Last PLAUGER				4. DATE OF DEATH Month APRIL Day 14 Year 19 57			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-8-95	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 14 Days 19 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Work at Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Jackson Dinges		14. MOTHER'S MAIDEN NAME Mary Burner Dinges	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Ashby Lee Plauger IO-II County RD S'E			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA of lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (Cause undetermined) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 4-3 , 19 57 , to 4-14 , 19 57 , that I lost the deceased alive on 4-13-57 , 19 57 , and that death occurred at 1:00 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 6480 New Hampshire Ave. Hyattsville, Md.				DATE SIGNED 4/14/57			
ACTUAL SIGNATURE Howard S. Madigan M.D.				PHYSICIAN'S NAME (Type) Howard S. Madigan			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/16/1957		22c. NAME OF CEMETERY OR CREMATORY Plauger Cemetery	
22d. LOCATION (City, town, or county) Detrick (State) Virginia				23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.			
24a. REC'D BY REGISTRAR APR 22 57				24b. REGISTRAR'S SIGNATURE W. L. ...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04400

4416

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro				c. LENGTH OF STAY IN 1b 42 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Largo Road				e. STREET ADDRESS Largo Road.			
3. NAME OF DECEASED (Type or print) First Thomas Middle Henry Last Proctor				4. DATE OF DEATH Month April Day 22 Year 19 57.			
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1870	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Tobacco)				10b. KIND OF BUSINESS OR INDUSTRY Tenent		11. BIRTHPLACE (State or foreign country) Maryland.	
13. FATHER'S NAME Henry Proctor				14. MOTHER'S MAIDEN NAME Mollie Savoy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Upper Marlboro, Maryland. Mrs. Mary Proctor (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Interosclerosis, generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatitis							INTERVAL BETWEEN ONSET AND DEATH unk
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from Summer, 1950 , to 22 Apr, 1957 , that I last saw the deceased alive on 22 Apr, 1957 , and that death occurred at 5:20 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE R B Sasscer				DATE SIGNED 4-24-57			
PHYSICIAN'S NAME (Type) R. B. Sasscer, M.D.				ADDRESS (Street, city or town, state) Upper Marlboro, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.				ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR APR 25 57	
				24b. REGISTRAR'S SIGNATURE W. J. Smith			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04401

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4371

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 5702 30th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Luther Last Reid				4. DATE OF DEATH Month April Day 20 Year 1957			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-1881		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75	IF UNDER 24 HRS. Hours 75 Min. 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Reid				14. MOTHER'S MAIDEN NAME Florence			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. 1		17. INFORMANT Address Edwin Luthor Reid; Silver Springs, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) 1							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 21, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/57		22c. NAME OF CEMETERY OR CREMATORY Chestnut Grove		22d. LOCATION (City, town or county) (State) Herndon, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home				ADDRESS 14th Rainier Maryland		24a. REC'D BY REGISTRAR APR 25 '57	
						24b. REGISTRAR'S SIGNATURE Alb...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased John T. Malone		Sex Male		Race White		Age 60	
Date of Death April 25, 1957		Place of Death Home		Cause of Death Acute congestive heart failure		Manner of Death Natural	
Residence 2502 30th Avenue Kensington		Occupation None		Education None		Marital Status Married	
Signature of Medical Examiner John T. Malone		Signature of Coroner John T. Malone		Signature of Registrar John T. Malone		Signature of Burial Director John T. Malone	

BUREAU V. B.

APR 25 1957

RECEIVED

John T. Malone, M.D.

4375

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>9 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Richards</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 April 1957</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Wilton Richards</u>		14. MOTHER'S MAIDEN NAME <u>Cordelia Nies</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital records</u> Address <u>Cheverly Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abnormal pulmonary ventilation</u> <u>774X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumotaxia (2 hrs)</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:30 A M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.				ADDRESS (Street, city or town, state) <u>College Park, Md.</u> DATE SIGNED <u>4/4/57</u>			
PHYSICIAN'S NAME (Type) <u>Thomas A. Christensen</u>				<u>College Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 11 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077253 XVI

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04403

4346

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 5 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				d. STREET ADDRESS 4100 Oglethorpe Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4100 Oglethorpe Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPHINE SAVITSKI (Jozefa Sawicka)				4. DATE OF DEATH April 4th, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15th, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home			
11. BIRTHPLACE (State or foreign country) Poland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Matthew Newicz				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Helen S. Kiess, 4100 Oglethorpe St. Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cause anoxia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis & its life DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Ronald S. Fleischer M.D. 5432 Queens Chapel Road, 4/4/1957 PHYSICIAN'S NAME (Type) Ronald S. Fleischer West Hyattsville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE April 8 1957		24b. REGISTRAR'S SIGNATURE Mr. Jas. Severe <i>Deputy</i>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
John Doe		Male		45		Jan 1, 1910		New York City		Jan 15, 1957		Home		Heart Disease		Natural		J. Smith		A. Jones		Jan 16, 1957	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Signature of informant		21. Signature of registrar		22. Date of registration		23. Date of death		24. Date of burial	
Jane Doe		Wife		123 Main St		Baltimore		Maryland		21201		555-1234		B. Doe		C. Jones		Jan 16, 1957		Jan 15, 1957		Jan 18, 1957	

BUREAU V. R.

APR 11 1957

RECEIVED

4376

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First S. Middle HERBERT Last SCHAEFER		4. DATE OF DEATH Month APRIL Day 18 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-03
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Cashier & Ass't. Mgr. Bank		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John H. Schaefer		14. MOTHER'S MAIDEN NAME Mary Schaeffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577-22-2097	
17. INFORMANT Mrs. Ethel Boyd Schaefer-Hyattsville, Md.		Address 811 Somerset Pl.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease (c) myocardial infarct		INTERVAL BETWEEN ONSET AND DEATH 1 day months 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 57 , to April 18 , 19 57 , that I last saw the deceased alive on APRIL 17 , 19 57 , and that death occurred at 4:20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 905 Shandon St. Hyattsville Maryland DATE SIGNED 4-18-57 ACTUAL SIGNATURE Arnold A. Lee M.D. PHYSICIAN'S NAME (Type) Arnold A. Lee			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/20/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. H. Harris Co., Washington D.C.		24a. REC'D BY REGISTRAR DATE APR 23 57	
24b. REGISTRAR'S SIGNATURE W. H. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED John H. Robinson		AGE 45		SEX Male		RACE White	
DATE OF DEATH April 23, 1957		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		DISEASE OR INJURY Coronary Artery Disease		LOCALITY OF BIRTH Baltimore, Md.	
DATE OF BIRTH April 23, 1912		PLACE OF BIRTH Baltimore, Md.		OCCUPATION None		EDUCATION High School	
MARITAL STATUS Married		NAME OF SPOUSE Elizabeth Robinson		DATE OF MARRIAGE 1935		PLACE OF MARRIAGE Baltimore, Md.	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF HOSPITAL None		NAME OF NURSE None		NAME OF MINISTER None	
NAME OF FUNERAL HOME None		NAME OF CEMETERY None		NAME OF BURIAL PLACE None		NAME OF INTERMENT None	
NAME OF CORONER None		NAME OF JURY None		NAME OF JUDGE None		NAME OF CLERK None	
NAME OF REGISTRAR None		NAME OF CLERK None		NAME OF CLERK None		NAME OF CLERK None	

BUREAU V. S.

APR 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04405

4377

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Maryland		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt Rainier, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 3362 Chillum Road,.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Needham Middle Bascom Last Scott				4. DATE OF DEATH Month April Day 22 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1916		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oil Burner Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Key Company		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Scott				14. MOTHER'S MAIDEN NAME Ruby Spear			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Address Mrs Dora Scott Mt Rainier Maryland. (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic hepatitis 888.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (c) 888.3						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Absorption of chemicals used in cleaning.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Apr. 15 19 57		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Various places at which deceased worked.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED April 22, 1957			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER Ex			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2/23/57		22c. NAME OF CEMETERY OR CREMATORY Edwards Funeral Home		22d. LOCATION (City, town, or county) (State) Kinston Lenoir Co., N. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR APR 25 57	
				24b. REGISTRAR'S SIGNATURE W. L. Smith			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - ANNOTATE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
April 22, 1957		Home		Heart Disease	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]	

Registration of the death is required.

BUREAU V. 2

APR 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4378
CERTIFICATE OF DEATH

04406

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 4702 Riverdale, Rd.	
3. NAME OF DECEASED (Type or print) First Nola Middle Sherman Last		4. DATE OF DEATH Month April Day 24 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1900
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT William N Sherman		Address Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular (c) Renal Disease		INTERVAL BETWEEN ONSET AND DEATH 5 days 20 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6, 1954, to 4-24, 1957, that I last saw the deceased alive on 4-24-57, and that death occurred 9:00A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. Clum		ADDRESS (Street, city or town, state) 6110 43rd Ave	
PHYSICIAN'S NAME (Type) Dr. Clum		DATE SIGNED 4-25-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/57	
22c. NAME OF CEMETERY OR CREMATORY Morgan Cemetery		22d. LOCATION (City, town, or county) (State) Woodbine Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Joseph's Sons		24a. REC'D BY REGISTRAR DATE APR 29 57	
24b. REGISTRAR'S SIGNATURE Quelch			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Maryland		Female		40		April 21, 1900		Baltimore, Md.		Baltimore, Md.		Typhoid fever		April 28, 1957		10:30 AM		Home		J. Edgar Hoover		J. Edgar Hoover	
County		City		Street		Room		Occupation		Marital Status		Previous Illnesses		Last Meal		Last Seen Alive		Burial Place		Burial Date		Burial Time	
Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Single		None		None		None		None		None		None	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Health Officer		Signature of Police Officer		Signature of Fire Department		Signature of Water Department		Signature of Gas Company		Signature of Electric Company		Signature of Telephone Company		Signature of Cable Company	
J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover	

BUREAU V. 3

APR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4417
CERTIFICATE OF DEATH

04407

Reg. Dist. No.

734

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PR. GEO'S. CO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X / FRIENDLY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 7650- Allentown Road S.E.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ROSANNA S. SHIPLEY		4. DATE OF DEATH Month Day Year April 10th 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 16th 1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Sellner		14. MOTHER'S MAIDEN NAME Mary E. Biggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mrs. Minnie L. Goodwin	
17. INFORMANT Address 7650- Allentown Road S.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 176X Acemia DUE TO Hypertensive Heart Disease & myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Asymptomatic cell carcinoma Right Lobe of lung (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 10 days. 7 yrs. 7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1950, to 4-10 , 1957, that I last saw the deceased alive on 4/9/ , 1957, and that death occurred at 11:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7519- Broadview Road, Friendly, Md. DATE SIGNED 5/10/57 ACTUAL SIGNATURE Anna Coyne Todd M.D. PHYSICIAN'S NAME (Type) ANNA COYNE TODD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 12-57	
22c. NAME OF CEMETERY OR CREMATORY Bells Cemetery		22d. LOCATION (City, town, or county) (State) Camp Springs, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		24a. REC'D BY REGISTRAR 1661 - Good Hope Road S.E. Washington, D.C.	
24b. REGISTRAR'S SIGNATURE Carrie Campbell		DATE APR 11 1957	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES J. KELLY		Male		45		1912		New York		New York		New York		New York	
MARRIAGE		MARRIED		DATE		PLACE		CITY		COUNTY		STATE			
JAMES J. KELLY		MARRIED		1935		New York		New York		New York		New York			
DECEASED		DECEASED		DATE		PLACE		CITY		COUNTY		STATE			
JAMES J. KELLY		DECEASED		1957		New York		New York		New York		New York			
CAUSE OF DEATH		CAUSE OF DEATH		DATE		PLACE		CITY		COUNTY		STATE			
HEART DISEASE		HEART DISEASE		1957		New York		New York		New York		New York			
MANNER OF DEATH		MANNER OF DEATH		DATE		PLACE		CITY		COUNTY		STATE			
NATURAL		NATURAL		1957		New York		New York		New York		New York			
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTY		STATE			
JAMES J. KELLY		JAMES J. KELLY		1957		New York		New York		New York		New York			
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTY		STATE			
JAMES J. KELLY		JAMES J. KELLY		1957		New York		New York		New York		New York			

BUREAU V. E.

APR 11 1957

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. NAME OF DECEASED John A. Smith		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 10-15-1910	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Salesman		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 05-10-1935	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. DATE OF DEATH 04-10-1957	
13. SIGNATURE OF DECEASED John A. Smith		14. SIGNATURE OF WITNESS John A. Smith		15. SIGNATURE OF DECEASED John A. Smith		16. SIGNATURE OF WITNESS John A. Smith	
17. SIGNATURE OF DECEASED John A. Smith		18. SIGNATURE OF WITNESS John A. Smith		19. SIGNATURE OF DECEASED John A. Smith		20. SIGNATURE OF WITNESS John A. Smith	
21. SIGNATURE OF DECEASED John A. Smith		22. SIGNATURE OF WITNESS John A. Smith		23. SIGNATURE OF DECEASED John A. Smith		24. SIGNATURE OF WITNESS John A. Smith	
25. SIGNATURE OF DECEASED John A. Smith		26. SIGNATURE OF WITNESS John A. Smith		27. SIGNATURE OF DECEASED John A. Smith		28. SIGNATURE OF WITNESS John A. Smith	
29. SIGNATURE OF DECEASED John A. Smith		30. SIGNATURE OF WITNESS John A. Smith		31. SIGNATURE OF DECEASED John A. Smith		32. SIGNATURE OF WITNESS John A. Smith	
33. SIGNATURE OF DECEASED John A. Smith		34. SIGNATURE OF WITNESS John A. Smith		35. SIGNATURE OF DECEASED John A. Smith		36. SIGNATURE OF WITNESS John A. Smith	
37. SIGNATURE OF DECEASED John A. Smith		38. SIGNATURE OF WITNESS John A. Smith		39. SIGNATURE OF DECEASED John A. Smith		40. SIGNATURE OF WITNESS John A. Smith	
41. SIGNATURE OF DECEASED John A. Smith		42. SIGNATURE OF WITNESS John A. Smith		43. SIGNATURE OF DECEASED John A. Smith		44. SIGNATURE OF WITNESS John A. Smith	
45. SIGNATURE OF DECEASED John A. Smith		46. SIGNATURE OF WITNESS John A. Smith		47. SIGNATURE OF DECEASED John A. Smith		48. SIGNATURE OF WITNESS John A. Smith	
49. SIGNATURE OF DECEASED John A. Smith		50. SIGNATURE OF WITNESS John A. Smith		51. SIGNATURE OF DECEASED John A. Smith		52. SIGNATURE OF WITNESS John A. Smith	
53. SIGNATURE OF DECEASED John A. Smith		54. SIGNATURE OF WITNESS John A. Smith		55. SIGNATURE OF DECEASED John A. Smith		56. SIGNATURE OF WITNESS John A. Smith	
57. SIGNATURE OF DECEASED John A. Smith		58. SIGNATURE OF WITNESS John A. Smith		59. SIGNATURE OF DECEASED John A. Smith		60. SIGNATURE OF WITNESS John A. Smith	
61. SIGNATURE OF DECEASED John A. Smith		62. SIGNATURE OF WITNESS John A. Smith		63. SIGNATURE OF DECEASED John A. Smith		64. SIGNATURE OF WITNESS John A. Smith	
65. SIGNATURE OF DECEASED John A. Smith		66. SIGNATURE OF WITNESS John A. Smith		67. SIGNATURE OF DECEASED John A. Smith		68. SIGNATURE OF WITNESS John A. Smith	
69. SIGNATURE OF DECEASED John A. Smith		70. SIGNATURE OF WITNESS John A. Smith		71. SIGNATURE OF DECEASED John A. Smith		72. SIGNATURE OF WITNESS John A. Smith	
73. SIGNATURE OF DECEASED John A. Smith		74. SIGNATURE OF WITNESS John A. Smith		75. SIGNATURE OF DECEASED John A. Smith		76. SIGNATURE OF WITNESS John A. Smith	
77. SIGNATURE OF DECEASED John A. Smith		78. SIGNATURE OF WITNESS John A. Smith		79. SIGNATURE OF DECEASED John A. Smith		80. SIGNATURE OF WITNESS John A. Smith	
81. SIGNATURE OF DECEASED John A. Smith		82. SIGNATURE OF WITNESS John A. Smith		83. SIGNATURE OF DECEASED John A. Smith		84. SIGNATURE OF WITNESS John A. Smith	
85. SIGNATURE OF DECEASED John A. Smith		86. SIGNATURE OF WITNESS John A. Smith		87. SIGNATURE OF DECEASED John A. Smith		88. SIGNATURE OF WITNESS John A. Smith	
89. SIGNATURE OF DECEASED John A. Smith		90. SIGNATURE OF WITNESS John A. Smith		91. SIGNATURE OF DECEASED John A. Smith		92. SIGNATURE OF WITNESS John A. Smith	
93. SIGNATURE OF DECEASED John A. Smith		94. SIGNATURE OF WITNESS John A. Smith		95. SIGNATURE OF DECEASED John A. Smith		96. SIGNATURE OF WITNESS John A. Smith	
97. SIGNATURE OF DECEASED John A. Smith		98. SIGNATURE OF WITNESS John A. Smith		99. SIGNATURE OF DECEASED John A. Smith		100. SIGNATURE OF WITNESS John A. Smith	

BUREAU V. S.

APR 23 1957

RECEIVED

4419

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vista</u>				c. LENGTH OF STAY IN 1b <u>25 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Issac</u> Last <u>Snowden</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 23 1898</u>	
9. AGE in years last birthday <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William Snowden</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-36-0002</u>		17. INFORMANT Address <u>Mary E. Snowden Vista, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Coronary Occlusion</u> DUE TO (b) <u>Congestive Heart failure</u> DUE TO (c) <u>Atherosclerotic Heart Disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 1955, to <u>April 17</u> , 1957, that I last saw the deceased alive on <u>April 1</u> , 1957, and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>9005 Volta St., Lanham, Md.</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>Dr. Henry A. Wise Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Henry A. Wise Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-22-51</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Family</u>		22d. LOCATION (City, town, or county) (State) <u>Woodman, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington Son</u> ADDRESS <u>467 N. St. N. W. Wash.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 28 1957

RECEIVED

1

04410 234

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4420

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland	c. LENGTH OF STAY IN 1b 9 Months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Oxon Hill, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 16500- Circle Drive S.E.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last NELLIE SOUTHERLAND		4. DATE OF DEATH Month Day Year April 28th. 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4-1879
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John R. Thomas	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Lillian S. Prinkey - 6500- Circle Drive S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior-arterial Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 18, 1954, to April 28, 1957, that I last saw the deceased alive on April 25, 1957, and that death occurred at 7:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Vital H. Paganello		ADDRESS (Street, city or town, state) 4912 Deal Dr. Wash 21, D.C.	
PHYSICIAN'S NAME (Type) VITALE H. PAGANELLO, M.D.		DATE SIGNED 4912 DEAL DR. Wash 21, DC.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 1st 1957	22c. NAME OF CEMETERY OR CREMATORY Chicamuxen Cemetery	22d. LOCATION (City, town, or county) (State) Chicamuxen, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		24a. REC'D BY REGISTRAR DATE MAY 1 1957	
ADDRESS 1661- Good Hope Road SE Washington 20, D.C.		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH Baltimore, Maryland		MARRIAGE None		EDUCATION None	
DATE OF DEATH May 1, 1957		PLACE OF BIRTH Baltimore, Maryland		AGE None	
SEX Male		RACE White		RELIGION None	
OCCUPATION None		MILITARY SERVICE None		PREVIOUS ILLNESS None	
CAUSE OF DEATH None		MANNER OF DEATH None		SIGNATURE OF DECEASED None	
SIGNATURE OF PHYSICIAN None		SIGNATURE OF WITNESS None		SIGNATURE OF REGISTRAR None	

BUREAU V. 2

MAY 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04411
345

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6000--48th Avenue		d. STREET ADDRESS 6000--48th Avenue	
3. NAME OF DECEASED (Type or print) First MARION Middle ODEN Last SOWERS		4. DATE OF DEATH Month April Day 26th Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4th, 1880
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Reader (Retired) PEPCO		10b. KIND OF BUSINESS OR INDUSTRY Salem, Missouri	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathaniel Sowers		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-05-0558	
17. INFORMANT Roy Sowers		Address 6000--48th Ave. Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH One hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1956 , to April 25 , 19 57 , that I last saw the deceased alive on 4-15 , 19 57 , and that death occurred at 12:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Till Bergemann		DATE SIGNED 4314 GALLATIN ST. HYATTSVILLE, MD.	
PHYSICIAN'S NAME (Type) TILL BERGEMANN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/1957	
22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR Apr. 4, 1957	
		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Sowers	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 10, 1957	
AGE		SEX	
65 YEARS		MALE	
RACE		RELIGION	
WHITE		METHODIST	
BIRTH DATE		BIRTH PLACE	
JANUARY 10, 1892		BALTIMORE, MARYLAND	
MARRIAGE DATE		MARRIAGE PLACE	
JANUARY 10, 1915		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
PLACE OF DEATH		MANNER OF DEATH	
BALTIMORE, MARYLAND		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE		DATE	
JANUARY 10, 1957		JANUARY 10, 1957	

BUREAU V. 2

MAY 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4380

CERTIFICATE OF DEATH

04412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmont Hgts. Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				d. STREET ADDRESS <u>7016 59th Place</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>Ann</u> Last <u>Spriggs</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-26-54</u>	
9. AGE (In years lost birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child—None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Andrew</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father—Andrew Spriggs—7016-59th Pl., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Purulent Meningitis</u> <u>340.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Causative Organism</u> DUE TO (c) <u>Undetermined</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 2, 1957</u> , to <u>April 2, 1957</u> , that I last saw the deceased alive on <u>April 2, 1957</u> , and that death occurred at <u>12:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jolene W. Perkins</u>				M.D. <u>5301 Hamilton St., Hyattsville</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Perkins</u>				DATE SIGNED <u>4-2-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-5-57</u>		<u>Lincoln Memorial</u>		<u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Rollins</u>				ADDRESS <u>4339 Hunt Pl., NE</u>		24a. REC'D BY REGISTRAR DATE <u>APR 5 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>							

APR 5 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04413

Reg. Dist. No.

734

4421

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 211		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (JACK) John Edward Stein		4. DATE OF DEATH Month April Day 12 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1923
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months 33 Days 33 Hours 33 Min.	IF UNDER 24 HRS. Months 33 Days 33 Hours 33 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot		10b. KIND OF BUSINESS OR INDUSTRY Commercial	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jack P. Stein		14. MOTHER'S MAIDEN NAME Marie M. Memmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 577-22-7864	
17. INFORMANT Jack P. Stein, same as no. 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of the skull, crushed chest and abdomen (c) Fractures of both femurs, right forearm PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Driver of an automobile that ran off the road and struck tree		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile that ran off the road and struck tree	
20c. TIME OF INJURY Month, Day, Year 11:50 P. M. 4/ 11/ 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 211		20f. (City or town) (County) (State) Accokeek P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 4-16-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		24a. REC'D BY REGISTRAR Carrie Campbell	
ADDRESS Washington, D.C.		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: John Edward Stein SEX: Male AGE: 33 DATE OF BIRTH: Oct. 6, 1923

RESIDENCE: 1100 Brook Hill Drive CITY: Baltimore STATE: Md.

DATE OF DEATH: April 11, 1957 TIME OF DEATH: 11:57 PM

PLACE OF DEATH: Home CAUSE OF DEATH: Myocardial infarction

IMMEDIATE CAUSE OF DEATH: Coronary artery disease

UNDERLYING CAUSE OF DEATH: Coronary artery disease

DECEASED'S SIGNATURE: John E. Stein EXAMINER'S SIGNATURE: Jack A. Stein

DATE OF EXAMINATION: April 11, 1957 PLACE OF EXAMINATION: Home

REMARKS: hemorrhage and shock

REMARKS: fracture of the skull, crushed skull and ribcage

REMARKS: fracture of both femurs, right forearm

REMARKS: fracture of both femurs, right forearm

REMARKS: fracture of both femurs, right forearm

REMARKS: fracture of both femurs, right forearm

REMARKS: fracture of both femurs, right forearm

REMARKS: fracture of both femurs, right forearm

REMARKS: fracture of both femurs, right forearm

REMARKS: fracture of both femurs, right forearm

REMARKS: fracture of both femurs, right forearm

REMARKS: fracture of both femurs, right forearm

BUREAU V. 3

APR 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4381

CERTIFICATE OF DEATH

04414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md.</u>				c. LENGTH OF STAY IN 1b <u>17 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				d. STREET ADDRESS <u>7730 Finn Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Strohl</u> Last				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 24 1907</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joel F. Strohl</u>				14. MOTHER'S MAIDEN NAME <u>Clara Ballenger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>James Strohl (Nephew)</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 wks</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>3/17</u> , 19 <u>57</u> , to <u>4/3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/3</u> , 19 <u>57</u> , and that death occurred at <u>1:20 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Julius Kauffman</u> , M.D.				ADDRESS (Street, city or town, state)			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>Dr. J. Kauffman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				ADDRESS <u>3200 R.I. Ave. Mt. Rainier, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 8 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>							

BUREAU V. ST.

APR 8 1957

RECEIVED

4422

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges'			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hall				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) Snowden Woodrow First Middle Last Sweeney				4. DATE OF DEATH Month April Day 11 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1912	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 4 Days 11 Hours 11 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employed Chauffer				10b. KIND OF BUSINESS OR INDUSTRY State Roads Comm.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Samuel Snowden Sweeney				14. MOTHER'S MAIDEN NAME Ida Vermillion			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W. II 711-07-2570		17. INFORMANT Mrs. Snowden W. Sweeney- Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Obesity DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 30 min. 5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19 57				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Upper Marlboro Md				20g. (County) Prince Georges'		20h. (State) Md.	
21. I certify that I attended the deceased from 11 Apr , 19 57 , to 11 Apr , 19 57 , that I last saw the deceased alive on 11 Apr , 19 57 , and that death occurred at 11:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. B. Sasscer				DATE SIGNED 12 Apr 57			
PHYSICIAN'S NAME (Type) R. B. Sasscer, M.D.				ADDRESS (Street, city or town, state) Upper Marlboro, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem: Fort Myer, Va.		22d. LOCATION (City, town, or county) (State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.				24a. REC'D BY REGISTRAR APR 17 1957		24b. REGISTRAR'S SIGNATURE A. H. Seducks	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4423

CERTIFICATE OF DEATH

Reg. Dist. No.

04416

1. PLACE OF DEATH a. COUNTY <i>Pr Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Pr Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bowie</i>				c. LENGTH OF STAY IN 1b <i>27 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>901 Maple Ave</i>				d. STREET ADDRESS <i>1901 Maple Ave</i>			
3. NAME OF DECEASED (Type or print) First <i>Wade</i> Middle <i>Sweeney</i> Last <i>Sweeney</i>				4. DATE OF DEATH Month <i>April</i> Day <i>17</i> Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 18, 1884</i>	9. AGE (In years last birthday) <i>73</i> yrs.	IF UNDER 1 YEAR Months <i>17</i> Days <i>17</i> Hours <i>17</i> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Track foreman Railroad</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Track foreman Railroad</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
13. FATHER'S NAME <i>Pinkney Sweeney</i>				14. MOTHER'S MAIDEN NAME <i>Alice Hardy</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>2</i>		17. INFORMANT <i>Mary E. Sweeney - Bowie Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinomatosis</i> <i>177X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cancer of Prostate</i> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <i>Feb 1</i> , 19 <i>40</i> , to <i>April 17</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>4/16/57</i> , 19_____, and that death occurred at <i>6 A</i> . M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert S. McEney</i> M.D.				ADDRESS (Street, city or town, state) <i>402 Main Street,</i> DATE SIGNED <i>4/17/57</i>			
PHYSICIAN'S NAME (Type) <i>Robert S. McEney, M.D.</i>				Laurel, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/19/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St Barnabas Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Leland Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Busch Sore Hyattsville Md</i>				24. REG'D BY REGISTRAR <i>APR 22 1957</i>			
24b. REGISTRAR'S SIGNATURE <i>Agnes Yingling</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croome</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croome</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sager Road</u>		d. STREET ADDRESS <u>1 Sager Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Claude Winfield Jayman</u>		4. DATE OF DEATH Month Day Year <u>April 16 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY (Own or rented) <u>Tobacco Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A</u>	
13. FATHER'S NAME <u>Zadock Jayman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Oggle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>1-11-111111</u>	
17. INFORMANT <u>Nettie M. Jayman, same as 102</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Croome, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>APR 22 1957</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>R. D. Adair</u>		DATE	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 22 1957

RECEIVED

4382

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>2</u> hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>1 1/2 C Ridge Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>20 April 1957</u>		9. AGE (In years last birthday) yrs. <u>2</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William F Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Webber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address <u>Cheverly Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anoxia</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>1:55</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M Frawley</u>				ADDRESS (Street, city or town, state) <u>6805 Baltimore Boulevard</u>			
PHYSICIAN'S NAME (Type) <u>Dr. J. Frawley</u>				DATE SIGNED <u>College Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Casch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 24 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. F. Smith</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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APR 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 4-18-57 et

CERTIFICATE OF DEATH

04419

Reg. Dist. No. 245

4347

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5805 Queens Chapel Rd. Sacred Heart Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NOMA Middle M. Last THOMPSON		4. DATE OF DEATH Month April Day 7 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/1/71
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 0 Days 6	11. IF UNDER 24 HRS. Hours 6 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. - Secy.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benedict Thompson		14. MOTHER'S MAIDEN NAME Alice Lawn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dr. Charles W. Thompson		Address 7906 Riverside Dr., Cabin John, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR-Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) arteriosclerosis generalized			INTERVAL BETWEEN ONSET AND DEATH one day a month 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1 , 19 57 , to April 7 , 19 57 , that I last saw the deceased alive on April 7 , 19 57 , and that death occurred at 9:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F Collins		ADDRESS (Street, city or town, state) 322 H St NE	
PHYSICIAN'S NAME (Type) THOMAS F COLLINS M.D.		DATE SIGNED 4-7-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR April 9 1957		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased George Thompson		Sex Male		Age 38		Date of Birth April 5, 1919	
Place of Birth St. Louis, Mo.		Race White		Occupation None		Usual Residence 1000 E. 1st St., Baltimore, Md.	
Cause of Death Heart Disease		Immediate Cause Myocardial Infarction		Intermediate Cause Coronary Artery Disease		Underlying Cause Arteriosclerosis	
Date of Death April 10, 1957		Time of Death 10:30 AM		Place of Death Home		Attending Physician Dr. J. H. Smith	
Signature of Physician J. H. Smith		Signature of Registrar J. H. Smith		Signature of Informant J. H. Smith		Signature of Coroner J. H. Smith	

BUREAU V. 2

APR 11 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04420

4383

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>1 Hr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Darlene</u> Middle <u>xxxxxxx</u> Last <u>Tippett</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3, 1957</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		9. AGE (In years last birthday) yrs. <u>7</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Benjamin Clarence Tippett</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME <u>Geneva Kidwell</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Benjamin Clarence Tippett-Marlboro, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic pulmonary ventilation</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia (lived 1 hr)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 3, 1957</u> , to <u>April 3, 19 57</u> that I last saw the deceased alive on <u>April 3</u> 19 <u>57</u> , and that death occurred at <u>9:15P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.				ADDRESS (Street, city or town, state) <u>College Park, Md.</u>		DATE SIGNED <u>4/4/57</u>	
PHYSICIAN'S NAME (Type) <u>Thomas A. Christensen</u>				<u>College Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>4/6/57</u>		<u>Mt. Laurel Cem.</u>		<u>Upper Marlboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Bras Upper Marlboro</u>				24a. REC'D BY REGISTRAR <u>me</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Bras</u>	
				DATE <u>APR 8 57</u>			

BUREAU V.

APR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04421

4384

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Verhovnik				4. DATE OF DEATH Month April Day 19 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 April 1957	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 1 Days 4		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John William Verhovnik				14. MOTHER'S MAIDEN NAME Neva Juanita Wanderon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hyaline degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity (birth wt 2 lbs) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) College Park DATE SIGNED 4/19/57							
ACTUAL SIGNATURE Thomas A. Christensen M.D.				PHYSICIAN'S NAME (Type) Thomas A Christensen			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF May 1957		22c. NAME OF CEMETERY OR CREMATORY St. Francis Cemetery		22d. LOCATION (City, town, or county) (State) Cheverly Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Remm				ADDRESS Adm		24a. REC'D BY REGISTRAR W. J. ...	
24b. REGISTRAR'S SIGNATURE W. J. ...				DATE MAY 3 57			

2077321XVO

CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Sex [Illegible]	
Date of Birth [Illegible]		Age [Illegible]	
Place of Birth [Illegible]		Usual Residence [Illegible]	
Date of Death [Illegible]		Time of Death [Illegible]	
Cause of Death [Illegible]		Manner of Death [Illegible]	
Physician's Name [Illegible]		Hospital or Place of Death [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]	

BUREAU V. S.

MAY 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Gen. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Luther First Middle Last Walk Jr.		4. DATE OF DEATH April Month 8 Day Year 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 May 1935
9. AGE (In years last birthday) 21 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY D. C. Govt.	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Luther Walk Sr.		14. MOTHER'S MAIDEN NAME Daisy Allis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 250-50-8591	
17. INFORMANT Address Rozina Walk Same as # 2 (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 816X IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral laceration (c) Fracture of skull stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile in collision with an auto, telephone pole and tree,	
20c. TIME OF INJURY Month, Day, Year 11.00 o. m. 4-7-1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Street	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ardmore, Pr. Geo, Maryland		20f. (City or town) pole and tree, (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 8, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-11-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Gray Court		22d. LOCATION (City, town, or county) (State) D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Frager's Funeral Home Inc.		ADDRESS 389 E. E. St.	
24a. REC'D BY REGISTRAR APR 10 57		24b. REGISTRAR'S SIGNATURE Deedman	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

STATE OF NEW YORK DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased John J. Jones, Jr.		Date of Death April 10, 1910	
Place of Death New York City		Age 35 years	
Sex Male		Race White	
Cause of Death Hemorrhage and shock following a fall from a height of about 20 feet		Manner of Death Accidental	
Signature of Medical Examiner J. J. Jones, Jr.		Signature of Coroner J. J. Jones, Jr.	

BUREAU

APR 10

RECEIVED

4386

CERTIFICATE OF DEATH

04423

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly,				c. LENGTH OF STAY IN 1b 22 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. STREET ADDRESS 1817 Columbia Ave.,			
3. NAME OF DECEASED (Type or print) First Middle Last Katherine VIRGINIA Weast				4. DATE OF DEATH Month Day Year April 20 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 17, 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRESS MAKER (LATER) CLERK				10b. KIND OF BUSINESS OR INDUSTRY WOOLWORTH CO		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME JAMES WEAIST				14. MOTHER'S MAIDEN NAME FRANCES BUTLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 578-34-0803			
17. INFORMANT MRS MARGARET ROBINSON				Address 1817 COLUMBIA AV. LANDOVER, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerosis heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from April 10 , 19 57 , to April 21 , 19 57 , that I last saw the deceased alive on April 20 , 19 57 , and that death occurred on 4-20-57 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon Levitsky M.D.				ADDRESS (Street, city or town, state) WASHINGTON, D.C.			
DATE SIGNED 4/21/57							
PHYSICIAN'S NAME (Type) Dr. Leon Levitsky							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-24-1957		22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Washington, D.C.				24a. REC'D BY REGISTRAR APR 20 1957		24b. REGISTRAR'S SIGNATURE W. W. Chambers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4387

CERTIFICATE OF DEATH

04424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 8 Days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Irving , Middle M. , Last Weed			4. DATE OF DEATH Month April , Day 3 , Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-85		9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY machinist		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME William Weed			14. MOTHER'S MAIDEN NAME Mary L Mallory		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 198012743		17. INFORMANT Pauline Weed Address College Park, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Occlusion of left coronary artery (c) Coronary Arteriosclerotic Heart Disease					INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 1957 to April 1957 , that I last saw the deceased alive on April 1957 , and that death occurred at 10:50 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Dr. Walcott Etienne		M.D.		DATE SIGNED 4/4/57	
PHYSICIAN'S NAME (Type) Dr. Walcott Etienne					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 4/6/57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR APR 8 '57	
				24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04425

Reg. Dist. No. 245

4348

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			c. LENGTH OF STAY IN 1b 3 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3218 Chillum Road, Apt 302				d. STREET ADDRESS 1734 Evarts Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sabina Middle Last Windel				4. DATE OF DEATH Month April Day 17, Year 1957			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1894	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Schnell				14. MOTHER'S MAIDEN NAME ? ? ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address William H. Windel, 3218 Chillum Road Mt. Rainier, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO (b) Cardiovascular Renal disease. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED April 18, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/1957		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. H. Jones Co., Washington, D.C.</i>				24a. REC'D BY REGISTRAR APR 23 1957			
24b. REGISTRAR'S SIGNATURE <i>James Severy</i>				24c. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Doe	
Sex		Male	
Age		35 years	
Date of Death		April 1, 1957	
Place of Death		Washington	
Cause of Death		Acute congestive heart failure	
Contributing Cause		Hypertension	
Manner of Death		Natural	
Signature of Examiner		[Signature]	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	
Signature of Medical Examiner		[Signature]	

RECEIVED
APR 23 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4388 Item 11, Film 6213 1-11-57 et
CERTIFICATE OF DEATH

04426

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 8 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale 25 d. STREET ADDRESS 5021 Oglethorpe Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles E. Wood		4. DATE OF DEATH Month Day Year April 2 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-07
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert J. Wood		14. MOTHER'S MAIDEN NAME Eva M. Putnam	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 177 09 1548	
17. INFORMANT Charles W. Wood		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 25 min 6 mo.		INTERVAL BETWEEN ONSET AND DEATH 25 min 6 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/28/57 , 19 57 , to 4/2 , 19 57 , that I last saw the deceased alive on 4/2 , 19 57 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3800 Reservoir Rd. N.W. Washington DATE SIGNED 4/2/57 ACTUAL SIGNATURE Charles A. Hufnagel M.D. PHYSICIAN'S NAME (Type) Charles A. Hufnagel			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 6, 1957	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR APR 5 57	
ADDRESS Hyattsville, Maryland.		24b. REGISTRAR'S SIGNATURE W. C. ...	

CERTIFICATE OF DEATH

4338

<p>NAME OF DECEASED <i>Albert J. Wood</i></p>		<p>DATE OF BIRTH <i>Jan 19 1905</i></p>		<p>PLACE OF BIRTH <i>Charles W. Wood</i></p>	
<p>DATE OF DEATH <i>Apr 5 1957</i></p>		<p>PLACE OF DEATH <i>Home</i></p>		<p>CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>SEX <i>Male</i></p>		<p>AGE <i>52</i></p>		<p>OCCUPATION <i>None</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>RELIGION <i>None</i></p>		<p>PREVIOUS ILLNESS <i>None</i></p>	
<p>DATE OF INTERMENT <i>Apr 5 1957</i></p>		<p>PLACE OF INTERMENT <i>Home</i></p>		<p>NAME OF FUNERAL HOME <i>None</i></p>	
<p>NAME OF PHYSICIAN <i>None</i></p>		<p>NAME OF NURSE <i>None</i></p>		<p>NAME OF MINISTER <i>None</i></p>	
<p>NAME OF CORONER <i>None</i></p>		<p>NAME OF JURY <i>None</i></p>		<p>NAME OF JUDGE <i>None</i></p>	
<p>NAME OF COUNTY CLERK <i>None</i></p>		<p>NAME OF STATE CLERK <i>None</i></p>		<p>NAME OF DEPARTMENT CLERK <i>None</i></p>	

BUREAU V. 2

APR 5 1957

RECEIVED

4389

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md				c. LENGTH OF STAY IN 1b 51 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md. 25				d. STREET ADDRESS 5415 55 th Place			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Zeller Last Zeller				4. DATE OF DEATH Month April Day 21 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1870	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86		IF UNDER 24 HRS. Months 86 Days 86 Hours 86 Min. 86			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. —			
17. INFORMANT Margaret L. Blatz				Address 381 Beverly Place, Beverly Beach, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized, severe 450.0 DUE TO (b) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) — DUE TO (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) —							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —				20g. (County) —		20h. (State) —	
21. I certify that I attended the deceased from 27 Jan , 19 57 , to 21 Apr , 19 57 , that I last saw the deceased alive on 20 Jan , 19 57 , and that death occurred at 10:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. J. Darrow				M.D. Wm. M. Darrow, M.D.			
PHYSICIAN'S NAME (Type) —				DATE SIGNED 4-21-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-24-57		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) Washington D C	
23. FUNERAL DIRECTOR'S SIGNATURE Neal Funeral Home				ADDRESS 4812 Ga Ave NW		24a. REC'D BY REGISTRAR WASH DC	
24b. REGISTRAR'S SIGNATURE —				DATE APR 23 57		24c. REGISTRAR'S SIGNATURE —	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

RECEIVED